

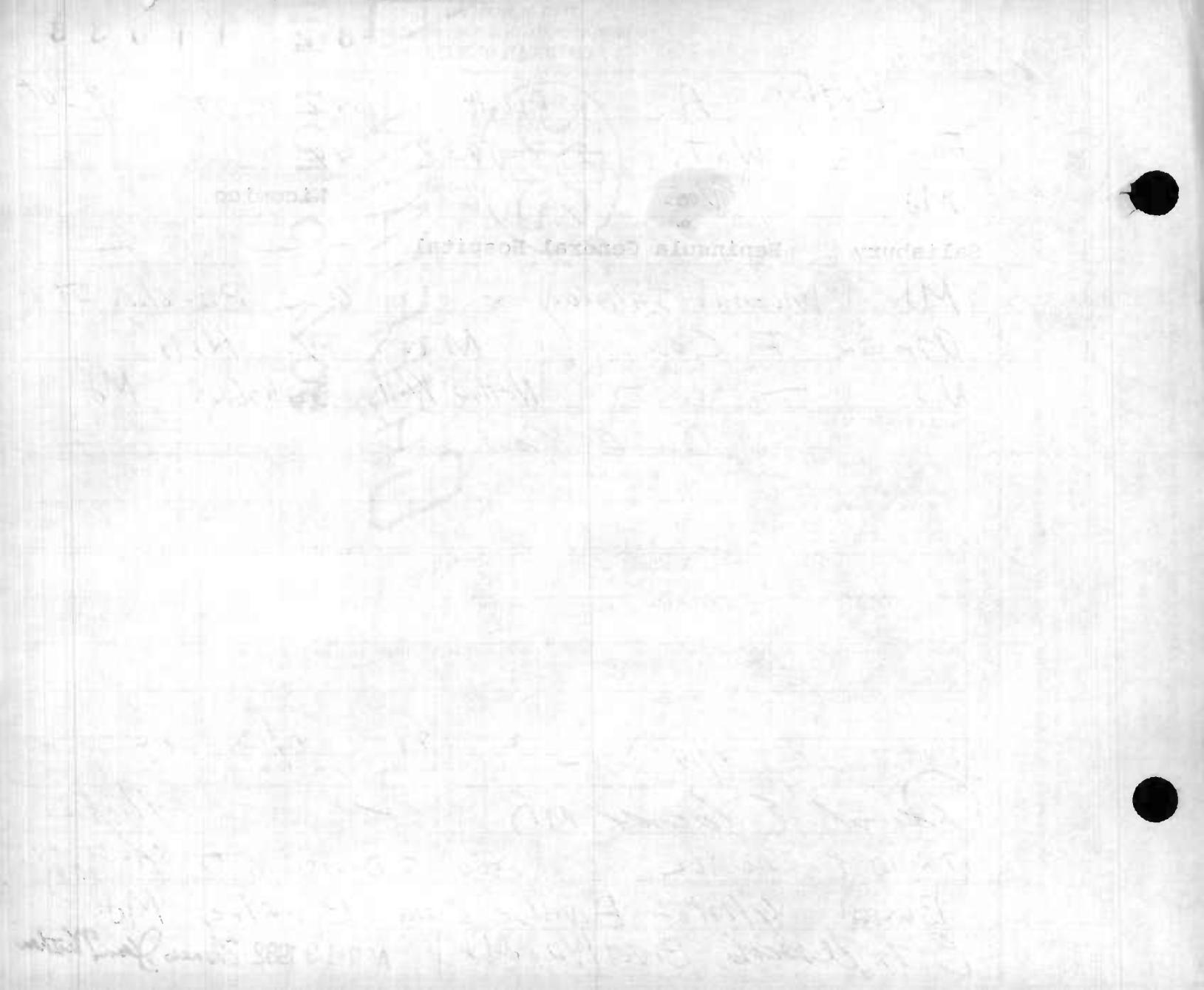
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												82	11	038			
												REG. NO.					
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR		
			Betty A.			Abbott			APRIL 15, 1982			82	15	1982	9:20A M		
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female			White			2-8-1938			44			MONTHS	DAYS	HOURS	MIN.		
7a BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.					
MD			U.S.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			Wicomico								
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY								
Salisbury			Peninsula General Hospital														
13a STATE 13b COUNTY			13c CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
MD			Wicomico			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			402 Back St.								
14 FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME MIDDLE LAST			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Omar F. Cox			Maxine V. Hill			No			-			Nettie Kelly, Salisbury, MD.					
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																	
1809																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			(b)														
			DUE TO, OR AS A CONSEQUENCE OF														
			(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death.			4/17/82			12 19 81 to 7/15 19 82											
22b. SIGNATURE David E. Cowan, MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 7/15/82								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID E. COWAN			22e. ADDRESS 1300 S. Division St. SALISBURY MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4/17/82			23c. NAME OF CEMETERY OR CREMATORIAL Bivalve Cem.			23d. LOCATION CITY OR TOWN Bivalve, MD								
24. FUNERAL DIRECTOR (NAME)									25a. DATE REC'D. BY REGISTRAR APR 19 1982			25b. REGISTRAR'S SIGNATURE Jan Martin					

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	1	1	0	3	9
1. FOR STATE REGISTRAR		REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)		FIRST KURT Kurt		MIDDLE J.		LAST BAGGAN Baggan		2d. DATE OF DEATH		MONTH	DAY	YEAR	2d. HOUR			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS						
Male		White		May 8, 1908		73		MONTHS		DAYS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		YRS.		HOURS		MIN.				
Germany		U.S.A.				Wicomico										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. INSIDE CITY LIMITS?		13d. STREET ADDRESS		12b. KIND OF BUSINESS OR INDUSTRY								
Salisbury		Peninsula General Hospital		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		113 D 112th St., Ocean City, Md.		Machinery Div.		Crown Cork Seal						
13a. STATE Maryland		13c. CITY OR TOWN Worcester		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		12b. KIND OF BUSINESS OR INDUSTRY								
		Ocean City		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		113 D 112th St., Ocean City, Md.		Machinery Div.		Crown Cork Seal						
14. FATHER'S NAME FIRST Johann		MIDDLE LAST Baggan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. 218-07-0385		17. INFORMANT Mrs. Lillian A. Baggan		ADDRESS 113 D 112th St.										
No																
18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest.</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		<u>Systemic Lupus Erythematosus</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
—		—		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>4-13</u> , 19 <u>82</u> , to <u>4-16</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>4-16</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>Michael Crouch</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4-19-82</u>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael Crouch</u>		22e. ADDRESS <u>P.O. Box 131, Salisbury, MD.</u>														
23a. BURIAL, CREMATION, REMOVAL SPECIFY <u>Burial</u>		23b. DATE <u>4-22-1982</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Loudon Park</u>		23d. LOCATION <u>Baltimore</u>		23e. COUNTY <u>Maryland</u>								
24. FUNERAL DIRECTOR NAME <u>Ruck Towson Funeral Home, Inc.</u>		ADDRESS <u>Towson, Maryland</u>		25a. DATE REC'D. BY REGISTRAR <u>APR 21 1982</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Martin</u>										
BP																

18.01.19

supper

1.30

W

00-170000

Indoor laundry cleaning

vacuuming

Wash clothes, clean up, wash clothes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be supplied of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	1	0	4	0		
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
HERBERT WILLIS									Bailey			4-17-82			9:02	A				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS					
male			white			MONTH Sept. DAY 23, YEAR 1910			71			MONTHS			DAYS			HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH		
Texas			USA						Wicomico			MD								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Salisbury			Peninsula General Hospital						retired carpenter											
13a. STATE 13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			114 Lynnhaven Acres								
Maryland			Worcester			Pocomoke														
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME			FIRST			LAST					
Layman			W.			Bailey			Beatrice						Lusk					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			(IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			114 ADDRESS								
no						217-05-4084			Anna Mae Bailey Pocomoke City, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Severe congestive heart failure								
DUE TO, OR AS A CONSEQUENCE OF (b)												Astroclerosis								
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 COPD. S/P Stroke, Multiple Pvc. Reentrant UGI, osteoarthritis																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
			None			<input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) did not view the body after death.			4/16/82			19			4/17			19			4/17			19		
22b. SIGNATURE			B. Agarwal			DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			4/17/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			B. Agarwal			ADDRESS			PGHMC Salisbury MD 21801											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			CITY OR TOWN			COUNTY			STATE		
Burial			4/20/82			St. Paul's Cemetery Marion Somerset			Md.											
24. FUNERAL DIRECTOR NAME			ADDRESS			25. DATE REC'D. BY REGISTRAR			26. REGISTRAR'S SIGNATURE											
Scott S. Nelson			Pocomoke City, Md.			APR 22 1982			Diane Johnson											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 11041					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED				MONTH	DAY	YEAR	2b. HOUR				
			Glenn	Wayne	Blevins	<input checked="" type="checkbox"/>				4	1	1982	M				
1. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN:	2c. DATE PRONOUNCED DEAD							
male	white	Mar. 1, 1950	32 yrs.	1	0					4	1	1982	2d HOUR 10:22				
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH PM								
Maryland		U. S. A.			<input type="checkbox"/>		<input checked="" type="checkbox"/>		Wicomico County								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Salisbury			Peninsula General Hsp					none			-----						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS							
Maryland			Wicomico		Salisbury			<input type="checkbox"/>		Snow Hill Road							
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
George Glenn Blevins			Evelyn T. Ellerbusch											213-76-9765		Evelyn T. Ellerbusch Denton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DUE TO, OR AS A CONSEQUENCE OF																	
DUE TO, OR AS A CONSEQUENCE OF																	
DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?									
								<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE 													Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion				
TITLE (SPECIFY) M.D. Assistant													MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn Street, Balto., MD 21201					DATE SIGNED 4/3/82									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 4-3-82		23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes		COUNTY	STATE						
24. FUNERAL DIRECTOR NAME Marvel-Short Funeral Home			ADDRESS Delmar, Del.					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE 							

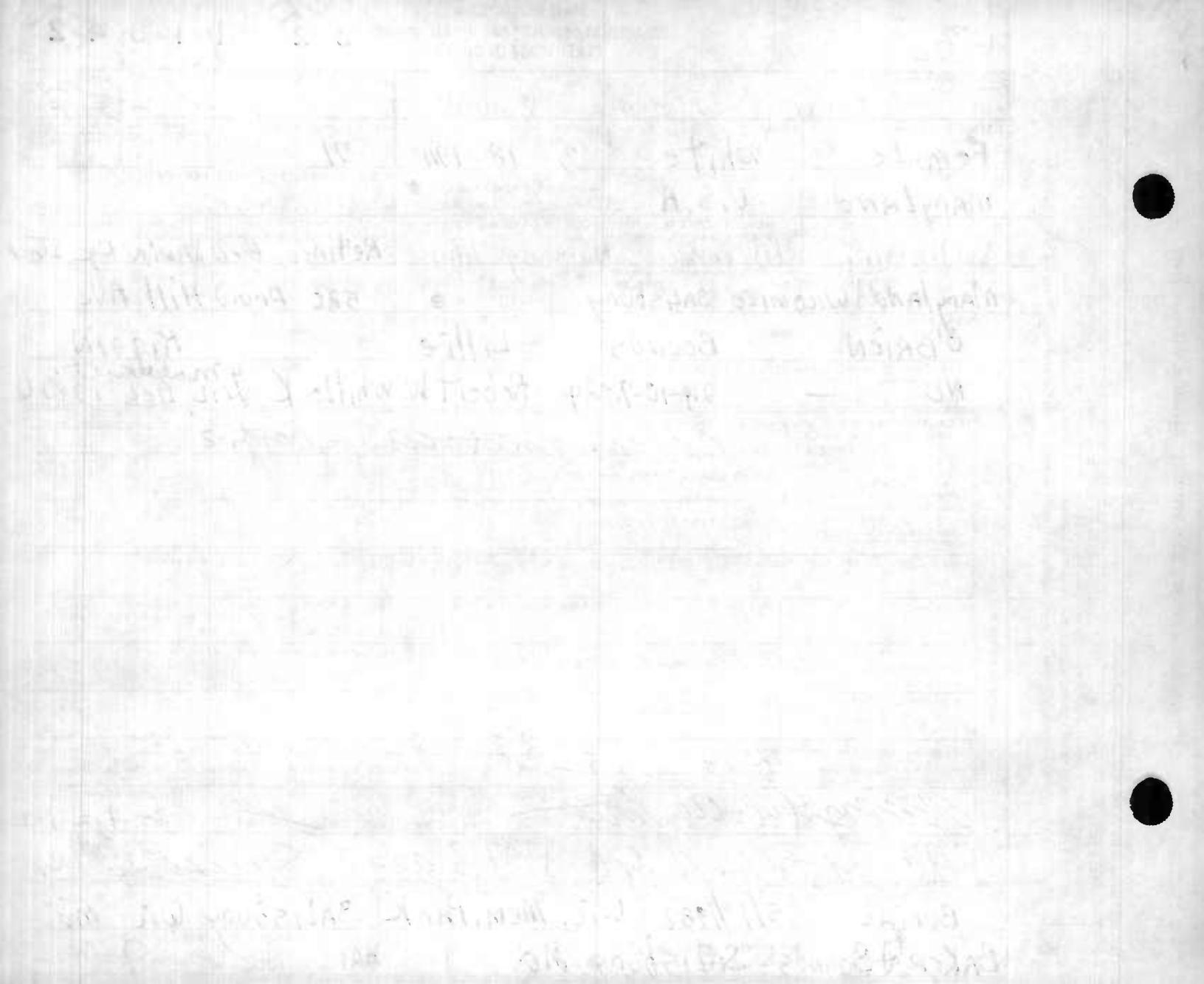
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										82 11042			
										REG. NO.			
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Mary Thelma Bounds						4 28 82			20 20 AM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR	
FEMALE			White			3 18 1911			71			YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH	
Maryland			U.S.A.						Wicomico			Salisbury	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Wicomico Nursing Home										Retired		Benjamin Pyle Store	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
Maryland			Wicomico			Salisbury						520 Prud Hill Ave	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
O'BRIEN			Bounds			Littie						Riggin	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No			- 214-10-9824			Robert W. Whitlock			4 Malcolm Ct.			W.L., Del 19810	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <i>Carcinomatosis - breast -</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) _____													
DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 10.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>3-25-82</i> to <i>4-19-82</i> , that (I) (we) last saw the deceased alive on <i>4-19-82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>HC Mitchell MD</i> DEGREE										22c. DATE SIGNED <i>29 April 82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>							
HC Mitchell, MD			P.O. Box 2378 Salisbury, MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			5/1/1982			Wic. Mem. Park			Salisbury, Wic. MD				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
BAKER & BOUNDS SALISBURY, MD.						MAY 3 1982							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 1 0 4 3							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR		
James									Bradley			April		13	1982	705PM			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS					
Male			White			MONTH 4 DAY 22 YEAR 13			68			MONTHS		DAYS		HOURS		MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
Salisbury			U.S.A.						Wicomico										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury			Peninsula General Hospital																
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
Md.			Wicco.			Salisbury						310 Poplar Hill Ave.							
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME							
Unkn.																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Unkn.			218-20-6945									4 days							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												Respiratory Failure							
4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease 30 years							
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4/13/82 to 4/13/82, that (I) (we) last saw the deceased alive on 4/13/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did not view the body after death.												22c. DATE SIGNED 4/13/82							
22b. SIGNATURE Roger Merrill			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger Merrill									DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 4/13/82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			CITY OR TOWN			COUNTY			STATE	
Removal			4/17/82																
24. FUNERAL DIRECTOR NAME Anatomy Board			25a. DATE REC'D. BY REGISTRAR APR 27 1982									25b. REGISTRAR Thomas J. Smith							

colmon

Intentional Intentional Information

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carboncoopers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8211044							
												REG. NO.							
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR		
			FRENE			G.			Brennan			APRIL 15, 1982					12 40		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS					
FEMALE			WHITE			MONTH 3 - DAY 14 - YEAR 05			77			MONTHS		DAYS		HOURS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.							
MASS.			USA						Wicomico										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Salisbury			Peninsula General Hospital			AT HOME													
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
MD			WOR			BERK						24078 OCEAN PINES							
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S M AIDEN NAME			FIRST			MIDDLE			LAST	
PAUL N.						MATHIEU			LEONA LEDOUX										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO			012-03-7736						DOROTHY HUBLEY			BERK MD							
4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost			(b)			arrest													
			(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE				
22a. I certify that (I) (the hospital) attended the deceased from 9/15/62 to 9/15/62, that (I) (we) last saw the deceased alive on 9/15/62, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED										
W. BEN HORNER MD									4/15/82										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			POWER ST SALISBURY MD 21801													
23a. BURIAL, CREMATION, REMOVAL (SPEC)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY			23e. DATE DIED BY REGISTRAR			23f. SIGNATURE				
BURIAL			4/19/82			ST. JOSEPH'S			U. BROOKFIELD			APR 19 1982			MASS.				
24. FUNERAL DIRECTOR NAME			ADDRESS																
ULLRICH Funeral Home BOSTON, MA.																			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1. FOR STATE REGISTRAR			2. DATE OF DEATH									2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	MONTH			DAY	YEAR	2b. HOUR					
BENJAMIN					BRITTINGHAM	9			6	92	5:55 P.M.					
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR					
MALE			BLACK		MONTH 9 DAY 6 YEAR 92			89			MONTHS	YEARS				
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			9. IF UNDER 1 HRS					
BERLIN, MARYLAND			U.S.A.					WICOMICO			MONTHS	HOURS				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
SALISBURY			PENINSULA GENERAL HOSPITAL									12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MARYLAND			13b. COUNTY WORCESTER		13c. CITY OR TOWN BERLIN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS ROUTE #2, BOX 69					
14. FATHER'S NAME JACOB			MIDDLE		LAST			15. MOTHER'S MAIDEN NAME ANDY			LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. -----		17. INFORMANT ANNIE FOOKS			18. ADDRESS Rt. #2, Box 67 BERLIN, MARYLAND			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO											3 HOURS					
18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			HEMORRHAGIC SHOCK									3 WEEKS				
1889 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) GROSS HEMATURIA									2 YEARS				
			DUE TO, OR AS A CONSEQUENCE OF (c) TRANSITIONAL CELL CARCINOMA MALIGNANT BLADDER NEOPLASM													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a MILD AZOTEMIA																
19a. DATE OF OPERATION 4/18/82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED UNCONTROLLED HEMATURIA						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4/18/82 to 4/18/82, that (I) (I) lost saw the deceased alive on 4/18/82, and that in my (my) opinion death occurred on the date and hour and from the causes stated above. I did not view the body after death.																
22b. SIGNATURE John H. Shenasky, MD			22c. DEGREE MD			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/18/82							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN H. SHENASKY, MD			22f. ADDRESS 16 MEDICAL CENTER, SALISBURY, MD			21801										
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL			23b. DATE 4/24/82			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS EVERGREEN CEMETERY			23d. LOCATION CITY OR TOWN BERLIN			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME JOLLEY MEMORIAL CHAPEL			ROUTE #2, JERSEY ROAD ADDRESS SALISBURY, MARYLAND			25a. DATE REC'D. BY REGISTRAR APR 29 1982			25b. REGISTRAR'S SIGNATURE John J. M. Foster							

BRUNSWICK, GEORGIA, MUSEUM

1992.26.99A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Failure 4 may be retained by the hospital or attending physician.



1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 0 4 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR					
BETTY JEAN STANLEY				BROWN			APRIL 19, 1982			32 PA M						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. HOUR						
FEMALE		NEGRO		MONTH	6	DAY	29	YEAR	34	IF UNDER 1 YEAR	IF UNDER 24 HRS					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS		10. DAYS	11. HOURS	12. MIN		
Laurel, Delaware		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			Wicomico			12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13. CITY OR TOWN			13a. STREET ADDRESS			13b. ADDRESS						
Salisbury		Peninsula General Hospital		Quantico			Route #347, Box 73			Route #1, Box 114 B						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Maryland		Wicomico		Quantico			YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	Route #347, Box 73							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT					
		John	B.	Stanley	Hattie			220-32-7732			Nathan McCoy					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO.		16c. ADDRESS			17. ADDRESS			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
		220-32-7732		Mardela Springs, Maryland			Route #1, Box 114 B									
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), 1(b), and 1(c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cause of the heart</i>																
1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 11</i> , 1982, to <i>April 19, 1982</i> , that (I) (we) last saw the deceased alive on <i>April 14, 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>David E. Cawell MD</i>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>4/19/82</i>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DAVID E. Cawell</i>		22f. ADDRESS <i>1300 S. Division St. Salisbury, MD 21801</i>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE BURIAL 4/24/82		23c. NAME OF CEMETERY OR CREMATORIAL ZION UNITED METHODIST			23d. LOCATION CITY OR TOWN SHARPTOWN		COUNTY WICOMICO		STATE MARYLAND					
24. FUNERAL DIRECTOR NAME JOLLEY MEMORIAL CHAPEL		ADDRESS Rt. #2, Jersey Rd.		25a. DATE REC'D. BY REGISTRAR APR 29 1982			25b. REGISTRAR'S SIGNATURE <i>Janice Jan Mather</i>									

1955.08.20. 2001.08.20.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 1 0 4 7																				
												REG. NO.																				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR														
Bernice Lydia									Bussells			APRIL 24, 1982						115 PM														
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?			9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Female			White			July 1, 1908			73			YRS.			Maryland			USA			Wicomico			Farming								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																							
Salisbury			Peninsula General Hospital																													
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS																				
Maryland			Wicomico			Salisbury			YES <input type="checkbox"/> NO <input type="checkbox"/>			St. Lukes Road																				
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY			ADDRESS														
Carl Leslie Bussells						Ethel			NO			Mr. Carlton W. Bussells (brother)			Same as 13																	
19. MEDICAL CERTIFICATION			20. DATE OF OPERATION			21. CONDITION FOR WHICH OPERATION WAS PERFORMED			22. AUTOPSY?			23. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																				
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>																				
24. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			25. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			26. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																							
28. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			29. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			30. LOCATION STREET CITY OR TOWN COUNTY STATE			YES <input type="checkbox"/> NO <input type="checkbox"/>																							
31. I certify that (I) (this hospital) attended the deceased from 01/22/82 to 04/20/82, that (I) (we) last saw the deceased alive on 04/24/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																																
32. SIGNATURE			33. DEGREE			34. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			35. DATE SIGNED																							
ROGER C. MERRILL MD												21/24/82																				
36. PHYSICIAN'S NAME (TYPE OR PRINT)			37. ADDRESS			38. BURIAL, CREMATION, REMOVAL (SPECIFY)			39. DATE			40. NAME OF CEMETERY OR CREMATORIUM			41. LOCATION CITY OR TOWN			42. COUNTY			43. STATE											
Burial			4/27/82			Union Church Cemetery			Salisbury			Wicomico			Maryland																	
44. FUNERAL DIRECTOR NAME			ADDRESS			45. DATE RECEIVED BY DIRECTOR/EXAMINER FOR REGISTRATION			46. APR 28 1982																							
HOLLOWAY FUNERAL HOME, Salisbury, Md.																																

BP _____

60886772

5001750

Chilean
Lettuce
General Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification should be attached.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 1 1 0 4 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
MARY E. CAREY						APRIL 21, 1982				3:15 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
F		W		MONTH NOV DAY 6, 1894 YEAR		87		MONTHS		DAYS	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
DELAWARE		USA						Wicomico		Salisbury	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											
Peninsula General Hospital											
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)											
12b. KIND OF BUSINESS OR INDUSTRY											
HOUSEWIFE											
13a. STATE											
MARYLAND		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
		WORCESTER		SHOWELL		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		SHINGLE LANDING ROAD			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. ADDRESS				
		DAVID	PASHER	BISHOP	HESTER		M. LEKITES				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		218-12-1632		DORIS C. WILLIAMS, SELBYVILLE, DEL.		Cardiogenic Shock		one day			
4960		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		2 years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		cor Pulmonale		Chronic obstructive & Restrictive Lung Disease		years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4. 15, 1982 to 4. 21, 1982, that (I) (we) last saw the deceased alive on 4. 21, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Pam M. Bishop		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 4.21.82			
22e. PHYSICIAN'S NAME (TYPE OR PRINT)											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 4-24-82		23c. NAME OF CEMETERY OR CREMATORIUM ODDFELLOWS CEM.		23d. LOCATION CITY OR TOWN BISHOPVILLE, WORC. MD.		23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME O. Frankford		ADDRESS FRANKFORD, DELAWARE		25a. DATE REC'D. BY REGISTRAR APR 27 1982		25b. REGISTRAR'S SIGNATURE Frances Jean Harten					
DHMH-16 50M 1/81 (VRA 15, 4)											

M

500 530 534

150 151 152

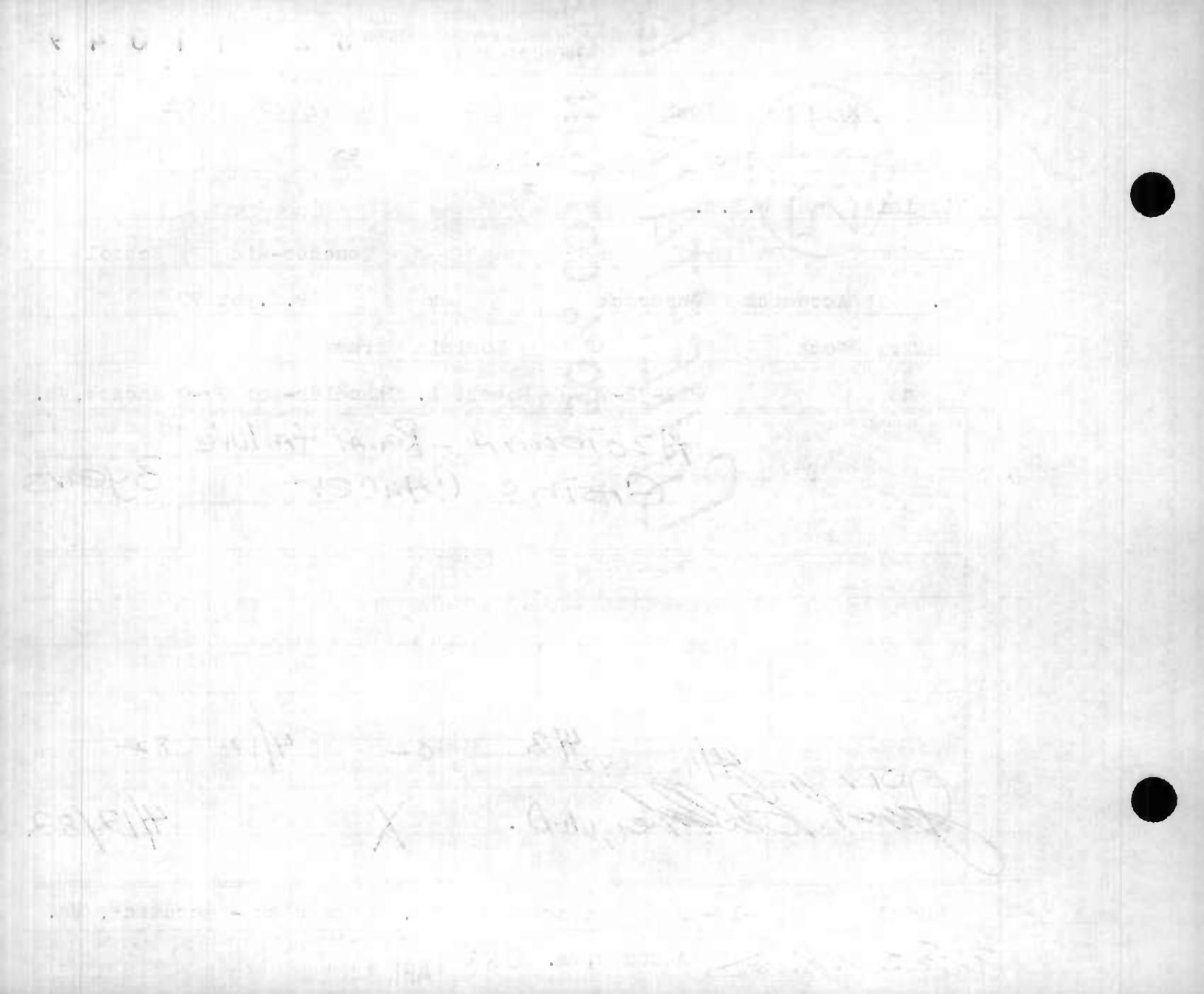
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18, show any injury or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8211049											
												REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Margaret Nock						Chandler						APRIL 12, 1982			12	10	AM	12 A M					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. DATE REC'D. BY REGISTRAR			IF UNDER 1 YEAR			IF UNDER 24 HRS					
Female			Black			MONTH DAY YEAR			52			APR 19 1982			MONTHS DAYS			HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Virginia			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Wicomico			Salisbury			Peninsula General Hospital			Teacher-Aid			School		
13a. STATE Va.			13b. COUNTY Accomack			13c. CITY OR TOWN Onancock			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS P.O. Box 77											
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST								
Harry Nock									Louisia Turner														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS														
NO			212-32-7096			Robert L. Chandler-Box 77-Onancock, Va.																	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
1519 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last												Azofermin - Renal failure Gastric Cancer 3 years											
DUE TO, OR AS A CONSEQUENCE OF (b)																							
DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1c																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1c OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (i) this hospital attended to deceased from 1982 to 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) did all views to body after death												4/12 1982 4/12 1982											
22b. SIGNATURE Marg. Chandler, M.D.			22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									23c. DATE SIGNED 4/12/82											
23a. PHYSICIAN'S NAME (TYPE OR PRINT)			23b. ADDRESS																				
Burial			4-15-82			Savageville Cem.			23d. LOCATION CITY OR TOWN Onancock - Accomack, Va.														
24. FUNERAL DIRECTOR Keith E. Chandler			ADDRESS Accomac, Va. 23301			25a. DATE REC'D. BY REGISTRAR APR 19 1982			25b. REGISTRAR'S SIGNATURE June J. Martin														

DHEM - 16 50M 1/81
(VRA 15, 4)

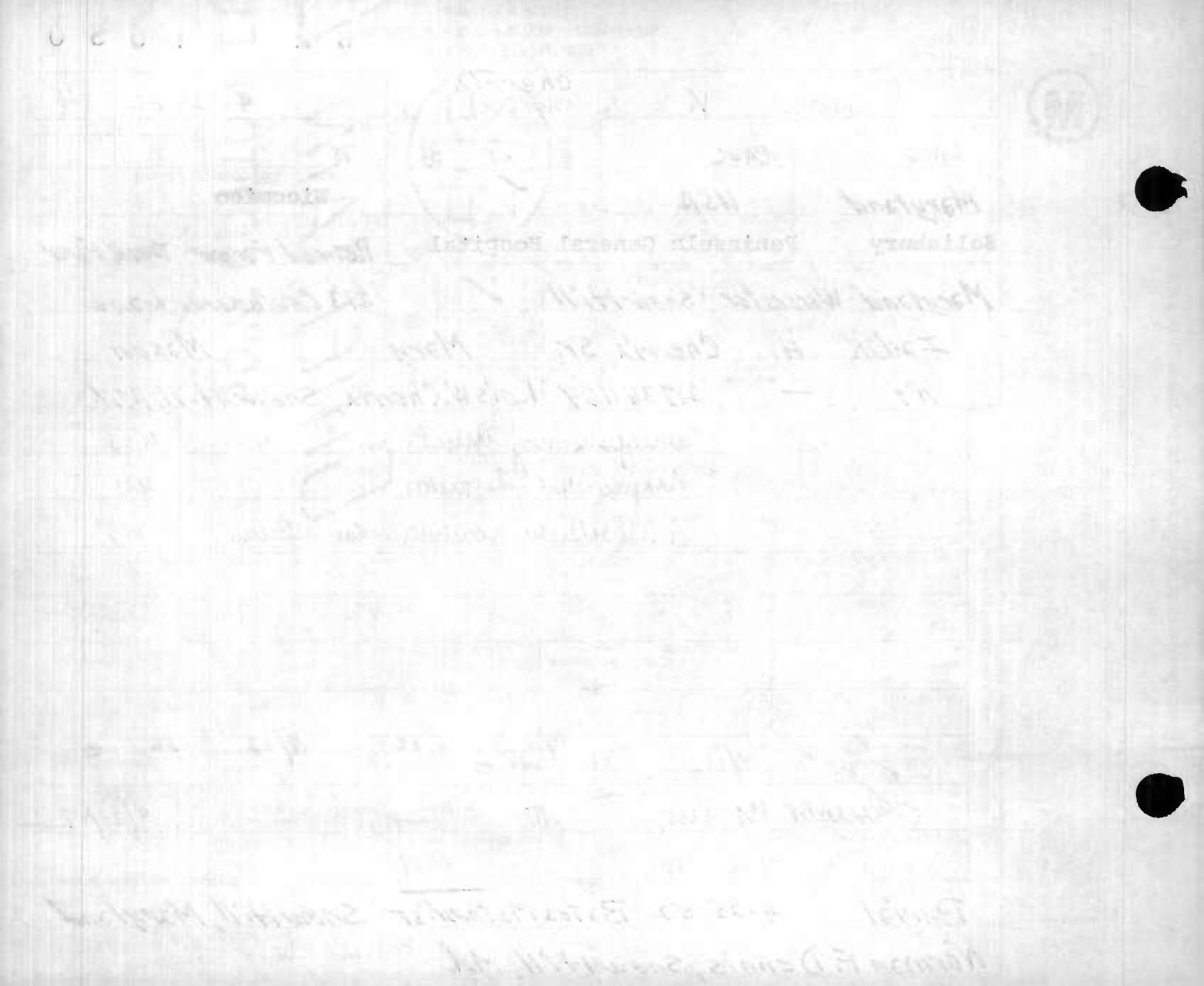


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be resubmitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on Item 18 above any injury or other traumatic event, the medical examiner

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8211050				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
HANCE V.						Cherrix CHERRIX			4 23 82					8:45	M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			CAUC			MONTH DAY YEAR			78			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			USA						Wicomico							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Salisbury			Peninsula General Hospital			Retired Farmer			Truck Farm							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Worcester			Snow 17, '11						213 Coulbourne Lane				
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME										
Zadok H. Cherrix Sr.						Mary										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH				
No			217361169			Lois W. Cherrix, Snow 17, '11, Md.						MINS				
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b and 18c) PART 1. DEATH WAS CAUSED BY																
IMMEDIATE CAUSE (a) <i>4100</i>												<i>Cardiogastroenteritis</i>				
DUE TO, OR AS CONSEQUENCE OF (b) <i>Myocardial Dystrophy</i>												HRS				
DUE TO, OR AS CONSEQUENCE OF (c) <i>Atherosclerotic Cardiovascular disease</i>												YRS				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(b)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
22a. INJURY OCCURRED			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21e. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that <input type="checkbox"/> (his hospital) attended the deceased from <i>4/13</i> 19 <i>82</i> to <i>4/23</i> 19 <i>82</i> that <input type="checkbox"/> (we) last saw the deceased alive on <i>4/23</i> 19 <i>82</i> and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.																
22b. SIGNATURE <i>Donald M. Wood</i>			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>4/23/82</i>							
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Donald M. Wood MD</i>			22g. ADDRESS <i>P.O. Box 111</i>													
23a. BURIAL, CREMATION, REMOVAL <input checked="" type="checkbox"/> Burial			23b. DATE <i>4-25-82</i>			23c. NAME OF CEMETERY OR Cremation <i>Bates Methodist</i>			23d. LOCATION CITY OR TOWN <i>Snow Hill, Maryland</i>							
24. FUNERAL DIRECTOR NAME <i>Norman F. Dennis, Snow Hill, Md.</i>			ADDRESS			25a. DATE SIGNED BY REGISTRAR <i>APR 20 1982</i>			25b. REGISTRAR'S SIGNATURE <i>Norman F. Dennis</i>							

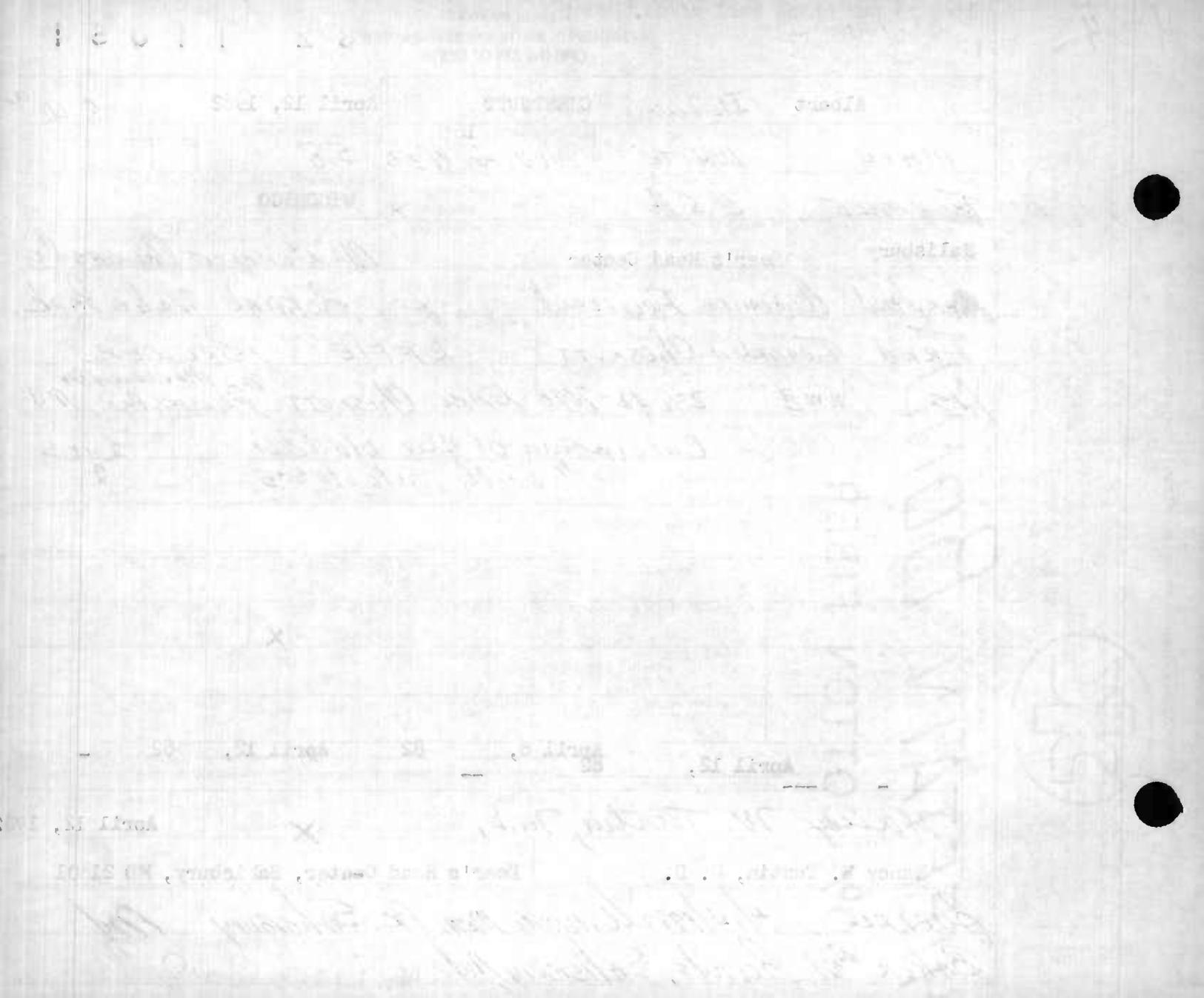


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

44			Item #5 per phone call w/Fun. Home		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8	2	1	1	0	5	1		
FOR 1 - STATE REGISTRAR			4/30/82 rc			CERTIFICATE OF DEATH			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Albert De-Lina CHESTNUTT						April 12, 1982						8:00 a					
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR	IF UNDER 1 YEAR			IF UNDER 24 HRS		
MALE			WHITE			16th			NOV.	6	1923	YRS			MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
TENNESSEE			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			WICOMICO								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Salisbury			Deer's Head Center			Maintenance			Painting Co.								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Maryland			Wicomico			Fruitland			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Bobrak Teacher Park					
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME			LAST			LAST					
FRED Franklin CHESTNUTT						EFFIE			Brewer								
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (ES. NO. OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
YES			239-42-7090			EARL CHESTNUTT			202 McNeeran Dr								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Carcinoma of the bladder									2 yrs					
1889			DUE TO, OR AS A CONSEQUENCE OF (b) with metastases														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 6, 1982, to April 12, 1982, that (we) last saw the deceased alive on April 12, 1982, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN			22c. DATE SIGNED		
Nancy W. Tustin, M.D.															April 12, 1982		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Deer's Head Center, Salisbury, MD 21801											
23a. BURIAL, CREMATION, REMOVAL (BY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY			STATE		
Burial			4/14/1982			Crown Hill Pk.			Salisbury			Md.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Baker & Bands, Salisbury, MD.						APR 19 1982			Nancy W. Tustin								

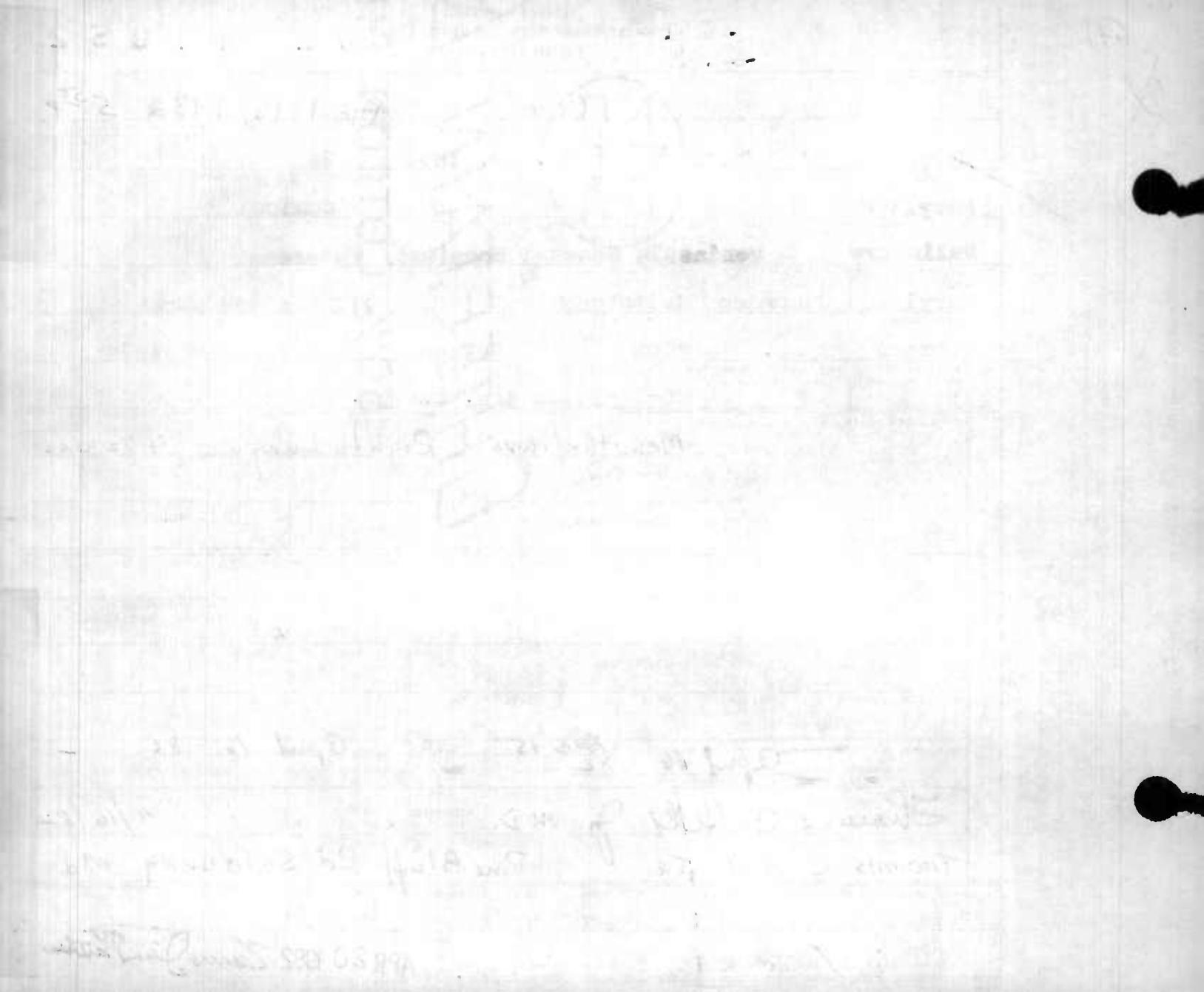


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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8211052				
REG. NO.																
1 - FOR STATE REGISTRAR			I DECEASED NAME FIRST Marvin Edwin			MIDDLE Cox			LAST			2a DATE OF DEATH MONTH Apr. 16, 1982	DAY 16	YEAR 1982	2b HOUR 5:50 P.M.	
3 SEX Male			4 RACE White			5. DATE OF BIRTH MONTH Jan. 19, 1896			YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 86	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS DAYS	2b HOUR 5:50 P.M.	
7a BIRTHPLACE STATE OR FOREIGN COUNTRY Maryland			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED WIDOWED			NEVER MARRIED DIVORCED			9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico				
10 CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman			12b. KIND OF BUSINESS OR INDUSTRY MD.							
13a STATE Maryland			13b COUNTY Wicomico			13c CITY OR TOWN Salisbury			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 311 Charles Street				
14 FATHER'S NAME FIRST Horace			MIDDLE H.			LAST Cox			15. MOTHER'S MAIDEN NAME FIRST Dorena			MIDDLE May			LAST Wallace	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b SOCIAL SECURITY NO. WW I			17. INFORMANT 220-32-0944A Mrs. Mary E. Cox (wife) same as 13			ADDRESS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 yrs	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Mesothelioma - Right Lung</u>																
1639 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.																
DUE TO, OR AS A CONSEQUENCE OF (b)																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN, COUNTY, STATE							
22a. I certify that (1) this hospital attended the deceased from <u>Dec 15, 1981</u> to <u>April 16, 1982</u> , that (1) <input type="checkbox"/> lost soul the deceased alive on <u>April 16, 1982</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.																
22b. SIGNATURE <u>Thomas C. Hill Jr.</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>4/16/82</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thomas C. Hill Jr.</u>			22e. ADDRESS <u>Pine Bluff Rd. Salisbury, Md.</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/19/82			23c. NAME OF CEMETERY OR CREMATORIUM Wicomico Memorial Park, Salisbury, Md.			23d. LOCATION CITY OR TOWN Salisbury, Md.			COUNTY				
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 20 1982			25b. REGISTRAR James Martin			STATE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 7/29/81
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	1	0	5	3
												REG. NO.						
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST M. MIDDLE CROSSLEY			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Anna												April 23 1982					7:00 P M	
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.				
Female			Caucasian			MONTH NOV DAY 3 1912			69			MONTHS		DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			U.S.A.						Wicomico									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Salisbury			Deer's Head Center															
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																		
13a. STATE Md.			13b. COUNTY Kent			13c. CITY OR TOWN Still Pond			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Main Street						
14. FATHER'S NAME FIRST Norris			MIDDLE C.			LAST Crew			15. MOTHER'S MAIDEN NAME FIRST Laura			MIDDLE Maude		LAST Latham				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
No			213-22-7539			Amanda C. Rambo			28618+									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																		
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																		
DUE TO, OR AS A CONSEQUENCE OF (b)																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (I) (his/her) attended the deceased from 10/29 19 81 to 14/23 19 82, that (I) (he) last saw the deceased alive on 4/23 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) (did not) view the body after death.			22b. SIGNATURE Inja J. Hwang, M.D.			DEGREE			ATTENDING PHYSICIAN		MEDICAL DIRECTOR	STAFF PHYSICIAN	22c. DATE SIGNED 4/23/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-27, 1982			23c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery			23d. LOCATION CITY OR TOWN Chestertown			COUNTY	STAFF MD					
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR APR 28 1982			25b. REGISTRAR'S SIGNATURE Anne Jan Newnam									

copy 50 1000

yes 1000

no 1000

no 1000

second time 1000

no 1000

no 1000

yes 1000

no 1000

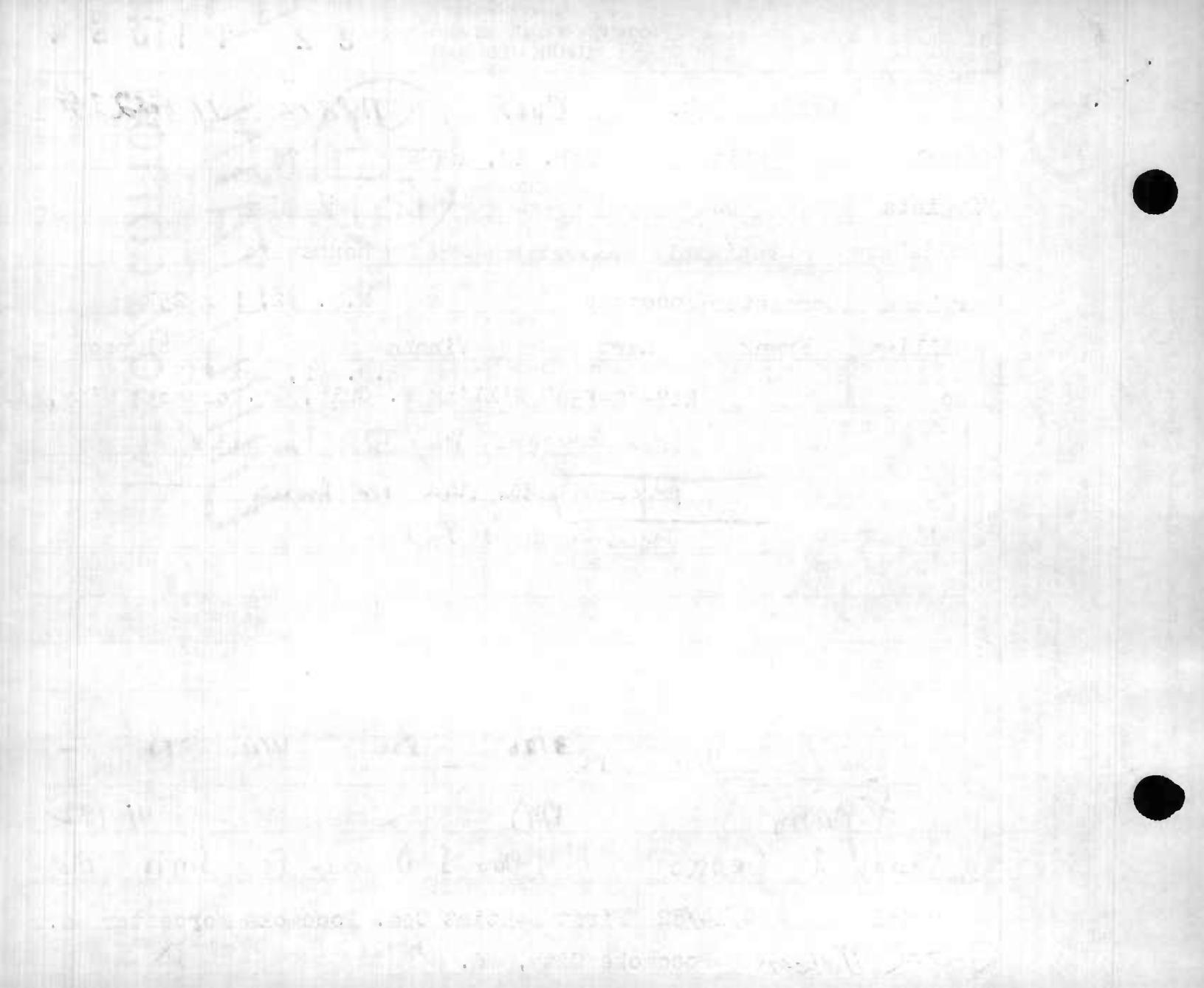
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 1 0 5 4	REG. NO.						
1 - FOR STATE REGISTRAR	1a. DECEASED NAME (TYPE OR PRINT)	FIRST MELVINA	MIDDLE S.	LAST CULP	2a. DATE OF DEATH APRIL 11 1982	MONTH 11	DAY 11	YEAR 1982	2b. HOUR 3 45 M		
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH Feb.	DAY 10	YEAR 1904	6. AGE (IN YEARS LAST BIRTHDAY) 78	IF UNDER 1 YEAR YRS	IF UNDER 24 HRS MONTHS	IF UNDER 24 HRS DAYS	2b. HOUR HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico	MD.					
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland	13b. COUNTY Worcester	13c. CITY OR TOWN Pocomoke	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS R.D. #2, Box 253							
14. FATHER'S NAME FIRST William	MIDDLE Frank	LAST Hart	15. MOTHER'S MAIDEN NAME FIRST Vianna	MIDDLE	LAST Simpson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-42-5504	17. INFORMANT R.D. #2, Box 253	ADDRESS William F. Culp, Sr. Pocomoke City, Md.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Colon Cancer, Stage II - Inoperable</i>											
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUETO OR AS A CONSEQUENCE OF (b) <i>perforated yesterday when s/p surgery</i> DUETO OR AS A CONSEQUENCE OF (c) <i>congestive heart failure</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/11</u> 19 <u>82</u> to <u>9/11</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9/11</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Joseph A. Grasso</i>											
22c. DEGREE <i>MD</i>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph A. Grasso</i>											
22e. ADDRESS <i>1300 S. Division St. Suis. Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/14/82	23c. NAME OF CEMETERY OR CREMATORIAL First Baptist Cem.	23d. LOCATION CITY OR TOWN Pocomoke	23e. COUNTY	STATE						
24. FUNERAL DIRECTOR NAME <i>Scott Melson</i>	ADDRESS Pocomoke City, Md.	25a. REGISTERED BY REGISTRAR APR 15 1982				25b. REGISTERED BY REGISTRAR APR 15 1982					



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	1	1	0	5	5
										REG. NO.						
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR						
1 DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		April 15 1982			4:00 A.M.				
FRED			William				DAVIS									
3 SEX Male			4 RACE White			5. DATE OF BIRTH MONTH DAY YEAR May 30, 1910			6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO			MD.				
10 CITY OR TOWN OF DEATH SALISBURY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT INCLUDE CITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman			12b. KIND OF BUSINESS OR INDUSTRY Nursery & produce							
13a. STATE Maryland			13b. COUNTY Wicomico			13c. CITY OR TOWN Salisbury			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 915 S. Division St.				
14. FATHER'S NAME FIRST Charlie			MIDDLE Davis			15. MOTHER'S MAIDEN NAME FIRST Annie			MIDDLE Smullen			LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Helen M. Davis (wife) same as 13			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR 1a, 1b, AND 1c.) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4292			DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCD</i> General Thrombosis			DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCD</i> General Thrombosis										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 3-13 1982 to 4-15 1982, that (I) (we) lost saw the deceased alive on 4-15 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Joseph C. Fitzgerald M.D.</i>										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22c. DATE SIGNED 4-15-82																
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH C. FITZGERALD, M.D.										22e. ADDRESS Salisbury, Maryland						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/18/82			23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park			23d. LOCATION CITY OR TOWN Salisbury			COUNTY Wicomico				
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland										25a. DATE REC'D. BY REGISTRAR APR 19 1982						
										25b. REGISTRAR'S SIGNATURE <i>Charles J. Fitzgerald</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 0 5 6					
										REG. NO.					
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR					
1 DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		4 - 21 - 82		11:59 M				
JOHN WALTER DAVIS															
3 SEX MALE			4 RACE CAUC.			5. DATE OF BIRTH MONTH 14 YEAR 25			6. AGE (IN YEARS LAST BIRTHDAY)						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico						
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WATERMAN					
13a. STATE MD			13b. COUNTY WORCESTER			13c. CITY OR TOWN OCEAN CITY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS RD #1 BOX 403 HARDOR DR			
14. FATHER'S NAME FIRST EDWARD			MIDDLE DAVIS			15. MOTHER'S M AIDEN NAME FIRST VENNIE			MIDDLE C A M B E L L						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 222 18 8967			17. INFORMANT ROBERT PARSONS			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac and Pulmonary collapse</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20-30 min.					
1416 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (b) <u>extensive carcinoma of the</u>					
										DUE TO, OR AS A CONSEQUENCE OF (c) <u>Possible metastatic spread of lungs</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 12</u> , 19 <u>82</u> , to <u>April 21</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>April 20</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>W. Charles Schaefer</u>										DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SCHAEFER, W.										22e. DATE SIGNED 4-21-82					
23a. BURIAL, CREMATION, REMOVAL TAYLORVILLE			23b. DATE 4/25/82			23c. NAME OF CEMETERY OR CREMATORIUM TAYLORVILLE			23d. LOCATION CITY OR TOWN BERLIN, WORCESTER			STATE MD			
24. FUNERAL DIRECTOR NAME Anna A. Burge			ADDRESS 108 WILLIAMS ST. BERLIN, MD 21811			25a. DATE APR 20 1982			25b. REGISTRAR'S SIGNATURE Anne J. Harter						

21816 81126

50 200 300

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120 400 500

130 450 550

140 500 600

150 550 650

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170 650 750

180 700 800

190 750 850

200 800 900

210 850 950

220 900 1000

230 950 1050

240 1000 1100

250 1050 1150

260 1100 1200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpaper. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	1	0	5	7
												REG. NO.						
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
			Gertrude Elaine DONAWAY						APRIL 15, 1982			10:07A.M.						
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female			White			Feb. 1, 1942			40			MONTHS		DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.						
Powellville, Md.			USA						Wicomico									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Salisbury			Peninsula General Hospital			Owner			Antique Shop									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Maryland			Wicomico			Powellville						Rt. 1, Mt. Hermon Road						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE (UNKNOWN)															
Bert Chandler			Jennie															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			ADDRESS						
NO			215-38-1181			Mr. Walter L. Donaway (Husband) same as 13												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cause of the lung</i>																		
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.																		
DUE TO, OR AS A CONSEQUENCE OF (b)																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from <i>12</i> to <i>4/15</i> 19 <i>82</i> , that (I) (we) lost now the deceased alive on <i>12/17/82</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>David E. Cowles, MD</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>4/15/82</i>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DAVID E. COWLES, MD</i>			22e. ADDRESS <i>1300 S. Division St Salisbury, MD 21801</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 4/17/82			23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory			23d. LOCATION CITY OR TOWN Lewes, Sussex, Delaware			25a. DATE REC'D. BY REGISTRAR APR 19 1982 <i>Frances Jean Hartner</i>						
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.			ADDRESS															

National Income accounting

1960

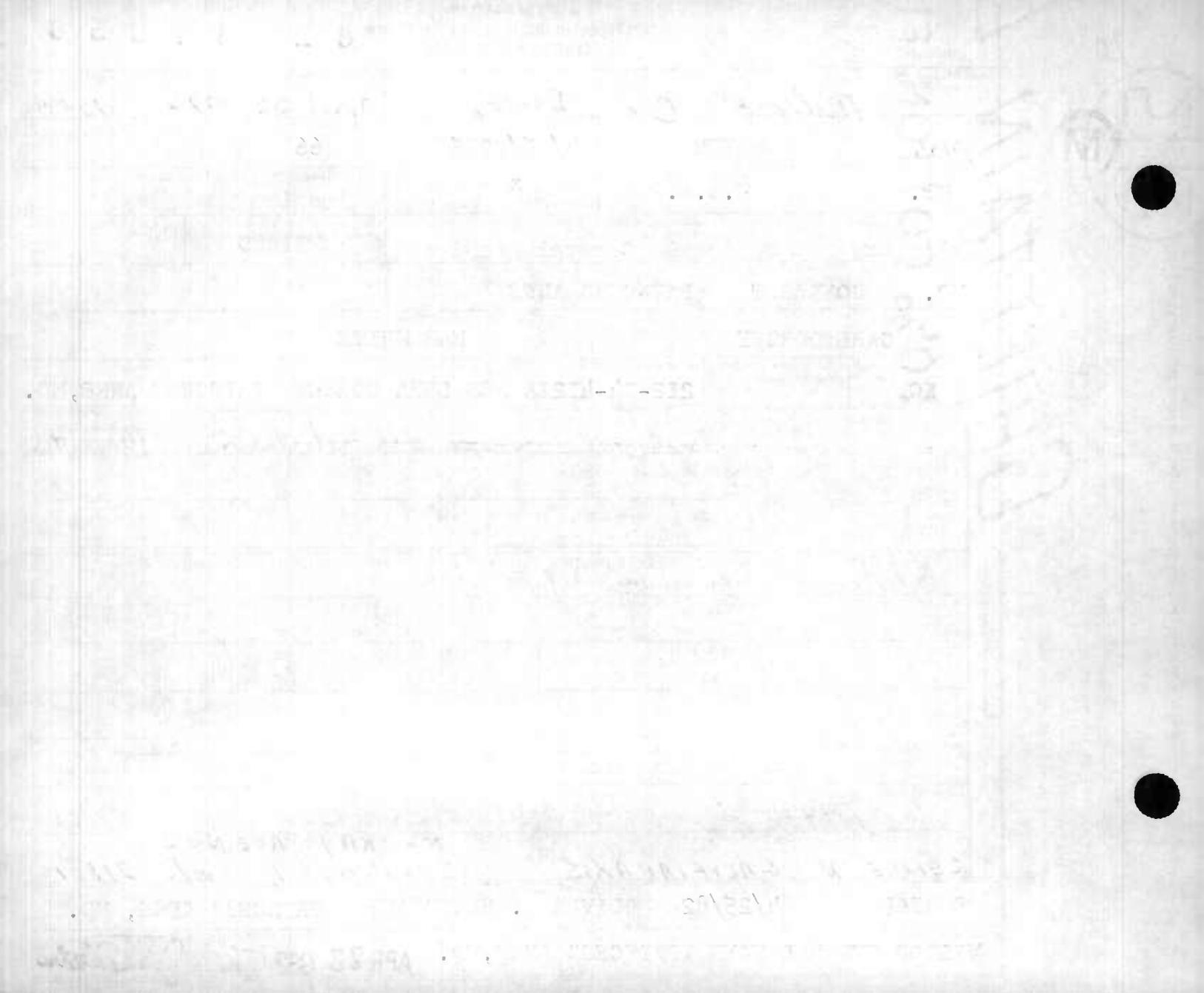
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be deposited for use as the burial permit. Then please remove carbon copies, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 1 0 5 8	
												REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			26. HOUR	
			<i>Milford E. Dorsey</i>						April 22, 1982			12:30 AM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male			WHITE			4/25/1915			66			MONTHS DAYS	
7. BIRTHPLACE COUNTRY			8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH			10. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 74 HRS	
MD.			U.S.A.			Wicomico			66			YRS	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR TRADE OR WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury			Peninsula General Hospital			13. CITY OR TOWN			13a. STREET ADDRESS				
13a. STATE COUNTY MD. SOMERSET			13. CITY OR TOWN PRINCESS ANNE			14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13a. STREET ADDRESS				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME MAE WHITE										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO			212-14-4121A			MES LENA DORSEY			PRINCESS ANNE, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Esophageal Carcinoma with metastasis</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 months	
1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.													
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Bilateral Pulmonary infiltrates</i>													
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>4-21-1982</i> to <i>4-22-1982</i> , that (I) (we) last saw the deceased alive on <i>4-21-1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>4/22/82</i>	
22b. SIGNATURE <i>George N. Galifianakis</i>			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>GEORGE N. GALIFIANAKIS</i>			22e. ADDRESS 306 KAY AVENUE SALISBURY, MD. 21801										
23a. BURIAL, CREMATION, REMOVAL (S) BURIAL			23b. DATE 4/25/82			23c. NAME OF CEMETERY OR CREMATORIUM OLIVER T. BEAUCHAMP			23d. LOCATION CITY STATE			23e. DATE REC'D. BY REGISTRAR APR 23 1982	
24. FUNERAL DIRECTOR WILSON FUNERAL HOME PRINCESS ANNE, MD.												25b. REGISTRAR'S SIGNATURE <i>Jan Wether</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 and 2 should be filled with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301-767-2220.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 1 0 5 9	
1 - FOR STATE REGISTRAR											REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
JAMES HAROLD DUNBAR									April 1, 1982			20 M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			2b. HOUR			
MALE		white		7 11 1918			63			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Pa		U.S.A.					WICOMICO						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A HOSPITAL, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING TIME)	
Hebron		N. Tournamline Dr										12b. KIND OF BUSINESS OR INDUSTRY Refined Strip Miner	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Maryland		Wicomico		Hebron						N. Tournamline Dr			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE										16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Campbell		Elizabeth											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. ADDRESS						
Yes		1938 to 34 PA176-14-1714		Cynthia Y. Bailey			See Sec 13a.						
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Atherosclerotic heart disease</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from saw the deceased alive on <u>Jan 1982</u> at <u>19</u>					22b. DEGREE			22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>4/1/82</u>			
22d. SIGNATURE <u>Clayton Raab m.o.</u>													
22e. ADDRESS <u>Box 49 Salisbury MD 21801</u>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN		23e. STAFF STAFF PHYSICIAN <input type="checkbox"/>		23f. DIRECTOR'S SIGNATURE <u>APR 6 1982</u>		
Burial		4/4/1982		Springhill Mem			Hebron, Md.						
24. FUNERAL DIRECTOR NAME <u>BAKER & BOUNDS</u>		ADDRESS <u>Salisbury, Md.</u>			25. ISTRAR'S SIGNATURE <u>APR 6 1982</u>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, an other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 1 0 6 0	
REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Selim Asaad Elias						April 13, 1982						11:30PM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR		
Male		White		MONTH DAY YEAR			57				IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED			8. MARRIED				8. MARRIED		
Egypt		USA		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			<input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. MARRIED		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Salisbury		814 Riverside Drive									Doctor Family		
13. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS		
Maryland		Wicomico		Salisbury			YES <input type="checkbox"/> NO <input type="checkbox"/>				814 Riverside Drive		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Asaad					Elias	Rose							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO			076-44-9728			Mrs. Lily H. Elias (wife) same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1629 <i>Bronchogenic carcinoma.</i>													
DUE TO, OR AS A CONSEQUENCE OF (b)													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic obstructive Pulmonary disease.</i>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/8 19 81 to 4/13 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Joseph Z. Badros</i>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/14/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 229 Florida Ave., Salisbury, Maryland										
Joseph Z. Badros, M.D.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment			23b. DATE 4/17/82			23c. NAME OF CEMETERY OR CREMATORIAL Wicomico Memorial Park			23d. LOCATION CITY OR TOWN Salisbury, Wicomico, Md.				
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.			25a. DATE REG'D. IN AG APR 19 1982 25b. REGISTRAR'S SIGNATURE <i>Charles J. Martin</i>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8211061	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR 5:40 P.M.	
Lloyd E. Esham									April 12 1982				
3. SEX MALE			4. RACE White			5. DATE OF BIRTH MONTH 8 DAY 25 YEAR 1905			6. AGE (IN YEARS LAST BIRTHDAY) 76			IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO			MD.	
10. CITY OR TOWN OF DEATH SALISBURY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL			12a. USUAL OCCUPATION Retired Auto Mechanic			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland			13b. COUNTY Wicomico			13c. CITY OR TOWN Salisbury			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 1301 Edgemont Ave	
14. FATHER'S NAME John			15. MOTHER'S MAIDEN NAME Minnie									14. LAST NAME Shockley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 217-10-3773			17. INFORMANT Helen P. Esham			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140			congestive heart failure										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease										
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Peripheral vascular insufficiency													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (the physician) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on April 12, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 4/12/82	
22b. SIGNATURE Rodney A. Wenrich, M.D.			22c. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RODNEY A. WENRICH			22e. ADDRESS 100 POWER ST. SALISBURY MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/15/1982			23c. NAME OF CEMETERY OR CREMATORIAL Wic Mem Park			23d. LOCATION CITY OR TOWN SALISBURY			COUNTY Wic	STATE Md.
24. FUNERAL DIRECTOR NAME Baker & Bounds			ADDRESS Salisbury, MD.			25a. DATE REC'D. BY REGISTRAR APR 19 1982			25b. REGISTRAR'S SIGNATURE Helen J. Baker				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical certification must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8211062	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Catherine			C.	EVANS		APRIL			9	1982		4:38 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
F			B			MONTH Dec. DAY 4, YEAR 1925			56			MONTHS	YEARS
7. BIRTHPLACE COUNTRY			8. CITIZEN OF WHAT COUNTRY?			9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS	
Md.			U.S.A.						Wicomico			MONTHS	HOURS
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury			Peninsula General Hospital			Laborer			Domestic				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Md.			Worcester Pocomoke						920-2nd St.				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS				
Charles					Collins	Mary			Rt. 1 Bx. 387 Pocomoke, Md.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. INFORMANT			16d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			213-22-5176			Rosie Collins			5 MIN				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												CARDIO RESPIRATORY ARREST	
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) LUNG CANCER	
DUE TO, OR AS A CONSEQUENCE OF (c)												UNKNOWN	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
3/2			Hemorrhagic Pericarditis & Tamponade			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			21g. CITY OR TOWN	21h. COUNTY	21i. STATE		
22a. I certify that (I) (this hospital) attended the deceased from 21/2/82, 19 82, to 4/9 82, 19 82, that (I) (we) last saw the deceased alive on 4/8 82, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 4/10/82	
22b. SIGNATURE Paul Fleury			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Fleury			22e. ADDRESS 305 Tenth St Pocomoke City Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4-17-82			23c. NAME OF CEMETERY OR CREMATORIAL Georgetown Cem.			23d. LOCATION CITY OR TOWN Pocomoke, Md.			STATE Md.	
24. FUNERAL DIRECTOR NAME Samuel G. Savage			ADDRESS New Church, Va.			25. APPROVED BY DEPARTMENT OF PUBLIC RECORDS REGISTRAR'S SIGNATURE APR 19 1982							
BP													
DHMH-16 50M 1/81 (VRA 15, 4)													

19000000

Benignus Cenotaph Foundation

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 1 0 6 3							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR		
Alexander									FARRARE			April 7, 1982					5:35 P		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS					
MALE			NEGRO			MONTH DAY YEAR			602			MONTHS DAYS		HOURS MIN.					
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH							
Md.			USA						Wicomico			Salisbury							
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Deer's Head Center												TRUCK DRIVER				MD			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
Md.			Dorchester			N.Mkt.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			P.O. #293 E.N. Mkt., Md.							
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME			LAST							
DORALAS			—			FARRARE			MAY			Conaway							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			ADDRESS							
NO			934-10-0676			Daughter Beverly Z. Farnare			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Approximate Interval Between Onset and Death							
1629						Special myelopathy													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.			(b)			DUE TO, OR AS A CONSEQUENCE OF													
			(c)			DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. LOCATION			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET			CITY OR TOWN			CITY OR TOWN		COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE							
E.P. Ritchings, M.D.												22c. DEGREE							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
Deer's Head Center, Salisbury, Md. 21801												22e. DATE SIGNED 4/7/82							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION			CITY OR TOWN							
BURIAL			4-10-82			Mt. Zion Cemetery			E.N. Market			PAR. 22. Md.							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REG'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
L.H. Boardley Cambridge, Md.						APR 15 1982													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8211064			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Richard Gant			Flexon			April 19, 1982			642 PM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS			
Male		White		June 18, 1895			86			IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
New Jersey		USA					Wicomico						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Salisbury		Peninsula General Hospital								Minister			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Maryland		Wicomico		Salisbury			YES <input type="checkbox"/> NO <input type="checkbox"/>			509 Hammond Street			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
R. G. Flexon		Emma Batchelor								16b. SOCIAL SECURITY NO			
										16c. ADDRESS Same as 13 Mrs. Ruth Flexon (daughter-in-law)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute myelogenous Leukemia</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
2050 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia</i>			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerotic</i> <i>Cardio vascular disease</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Malnutrition</i> , <i>Medications</i> , <i>Immunodeficient</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>4/19/82</i> to <i>4/19/82</i> , that (we) last saw the deceased alive on <i>4/19/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <i>Helen M. Baldado M.D.</i>			
22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22d. DATE SIGNED 4/20/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <i>5-17 F. RIVERSIDE DRIVE</i>											
HELEN M. BALDADO		<i>SALISBURY, MD. 21801</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 4/24/82		23c. NAME OF CEMETERY OR CREMATORIAL Washington Park East			23d. LOCATION CITY OR TOWN Indianapolis, Indiana			STATE			
Burial													
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME		ADDRESS Salisbury, Md.								25a. DATE REC'D. BY MEDICAL DIRECTOR APR 22 1982			
BP													

April 11, 1985

El Dorado

APR 15 1985

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RE-
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR RECORDS.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST.,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8211065
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR		
ALISTAR			C.	GILMORE		<input checked="" type="checkbox"/>	4-2-82			A M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.							
Male	White	5 24 00	81	MONTHS	DAYS	HOURS	MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH					
New York		U.S.A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Wicomico					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION FOR MOST OF WORKING LIFE		12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		Hotel Esther, E. Church St.			Manager		Food Store					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Md.		Wicomico		Salisbury		YES <input type="checkbox"/>		Hotel Esther, E. Church St.				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		LAST				
Alexander				Gilmore		Esther		L. Bunstein				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII			17. INFORMANT Dr. David Gilmore			ADDRESS Salisbury, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5533 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.											APPROXIMATE INTERVAL BEFORE DEATH MINUTES	
Esophageal Hemorrhage												
DUE TO, OR AS A CONSEQUENCE OF Para Esophageal Hernia with Ulceration												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?	
											<input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											and in my opinion	
ACTUAL SIGNATURE 											TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.											DATE SIGNED 4-2-82	
23a. CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
Removal		4/3/82										
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Anatomy Board		Balto., Md.			APR 12 1982		P. James Jan Wether					

1940-1941
MAGNETIC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Failure to do so may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours and sent with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8211066				
										REG. NO.				
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			EDITH LUCINDA			GORDY			APRIL 2 1982			11 AM		
3 SEX			4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
FEMALE			WHITE			MAR. 31, 1901			81			MONTHS DAYS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
DELAWARE			USA						Wicomico MD					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE SUCH ASYLUM, STATE ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury			Peninsula General Hospital			RETIRED								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
MARYLAND			WORCESTER			PITTSVILLE						PINE ST.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME											
FIRST WILLIAM MIDDLE A. LAST DAISEY			FIRST ANNA MIDDLE B. LAST DAISEY											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS					
			219-14-4668			RUSSELL J. DAVIS			FRANKFORD, DE.					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>														
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Artherosclerotic heart disease</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			<i>4/3/82</i>					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <i>4/3/82</i> 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>John R. Raab, M.D.</i> DEGREE										ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		
22c. DATE SIGNED										STAFF PHYSICIAN <input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
<i>John R. Raab, M.D.</i>			<i>Box 49 Salisbury MD 21801</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE		
BURIAL			4-6-82			ODDFELLOWS CEM.			BISHOPVILLE, WORCESTER, MD					
24. FUNERAL DIRECTOR NAME <i>John R. Raab</i>			ADDRESS							25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
										APR 6 1982			<i>John R. Raab</i>	

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Individual forming a ventral

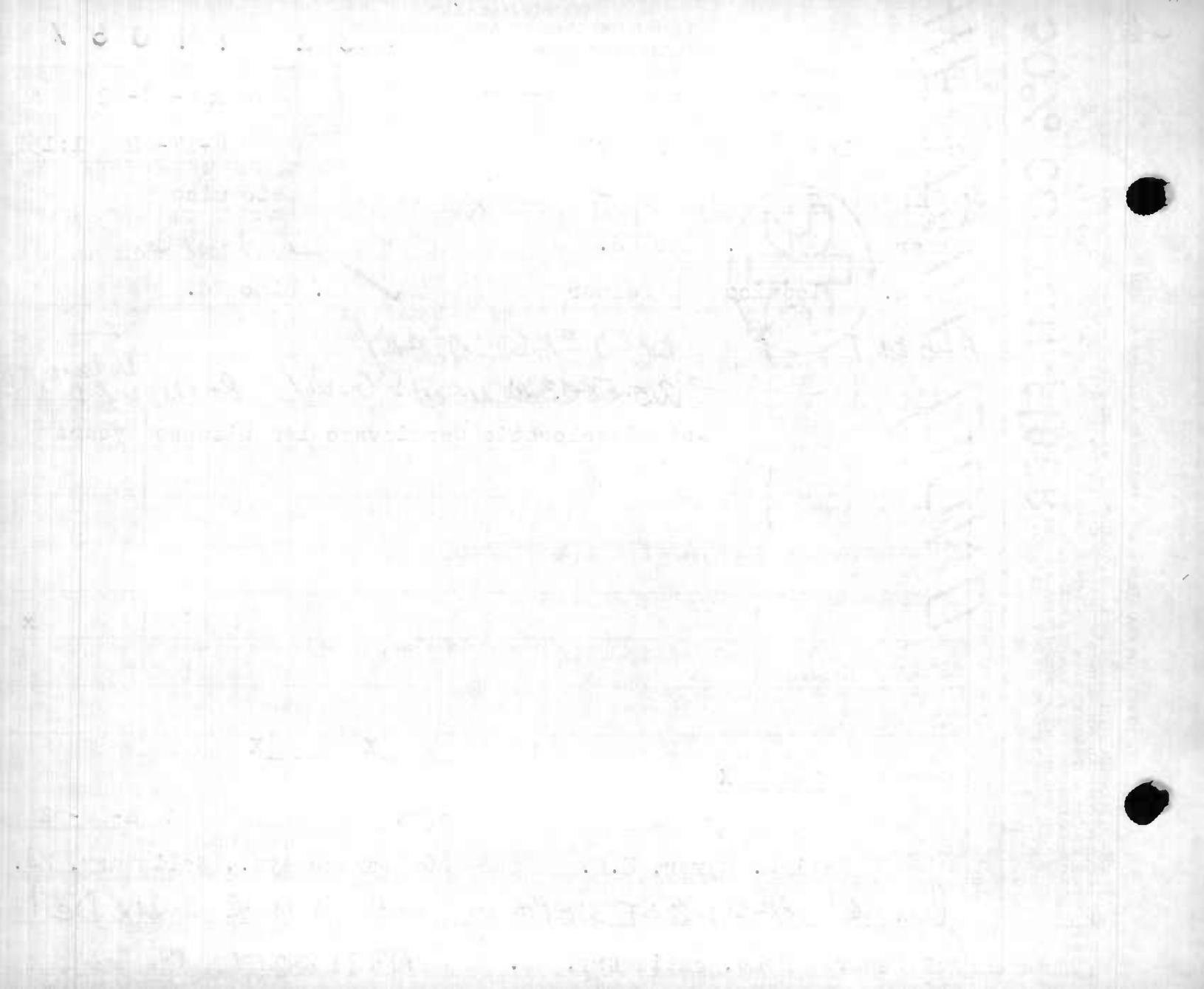
ventral

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 11067				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR
VIRGIE			LEE			GORDY						4-17-82				A
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR						
Female	Black	5 30 08	73	MONTHS	DAYS	4-17-82				A						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH								
N. CAROLINA		U. S. A.			X			Wicomico								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Delmar		E. Line Rd.			Housewife											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS								
Md.		Wicomico		Delmar		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. Line Rd.								
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME								
ALBERT		P		BORDERS		MARY										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
NO		215-58-0320		CLIFTON GORDY		Delmar, MD E. Line Rd.		years								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												Arteriosclerotic Cardiovascular Disease				
4392 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause last.												DUE TO, OR AS A CONSEQUENCE OF				
{ (b) DUE TO, OR AS A CONSEQUENCE OF																
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21g.												
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)												DATE SIGNED 4-19-82				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY			STATE					
Burial		4-23-82		ST STEPHENS		DELMAR		Sussex			Del					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
West Funeral Home, Salisbury, Md.				APR 21 1982		Thomas J. Parker										

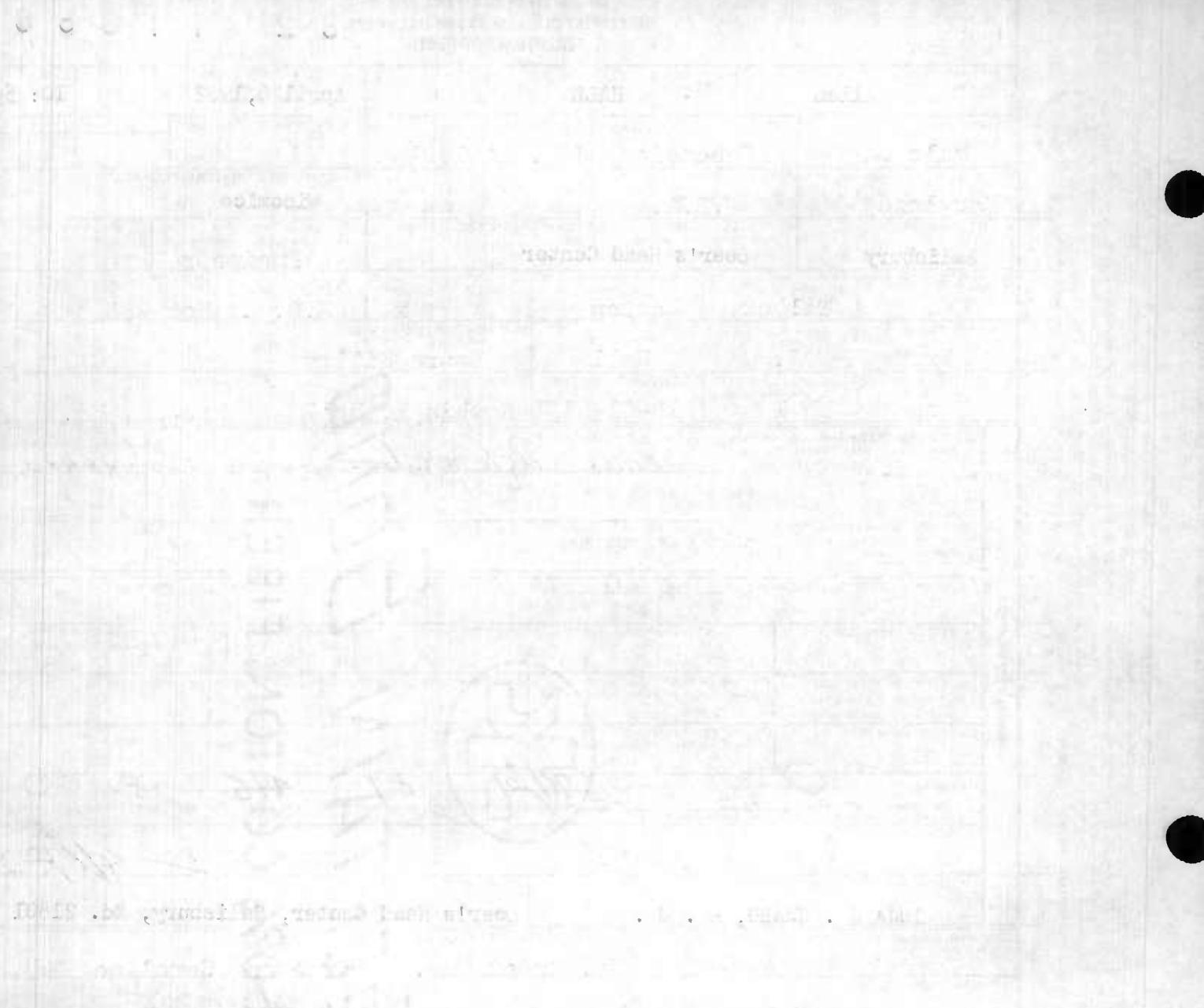


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 2 1 1 0 6 8											
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) Allen W. HALL						2a. DATE OF DEATH MONTH April 6, 1982			2b. HOUR 10:25p M											
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR JAN. 24 1901			6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.											
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			8. CITIZEN OF WHAT COUNTRY? U.S.A.			9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			10. CITY OR TOWN OF DEATH Salisbury											
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer			12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE Md.			13b. COUNTY Talbot		13c. CITY OR TOWN Easton			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS R.D. 2, Box 293			
14. FATHER'S NAME FIRST MIDDLE LAST Fred J. Hall			15. MOTHER'S MAIDEN NAME Laura Willey			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yess WW I			16b. SOCIAL SECURITY NO 213-01-8154			17. INFORMANT Sophie B. Hall			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7970 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c). DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this Hospital) attended the deceased from 7/1/21, 1981, to 4/6, 1982, that (I) (we) (did) not view the body after death. saw the deceased alive on 4/6, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.												22b. SIGNATURE John J. Hwang			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 4/6/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) INJA J. HWANG, M.D.			22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-9-82			23c. NAME OF CEMETERY OR CREMATORIAL Jr. Order Cem.			23d. LOCATION CITY OR TOWN Preston, Caroline, Md.			23e. COUNTY Caroline					
24. FUNERAL DIRECTOR NAME Newnam Funeral Home			ADDRESS Easton, Md.			25a. DATE REC'D. BY REGISTRAR APR 12 1982			25b. REGISTRAR'S SIGNATURE John J.														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or once

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	1	0	6	9								
												REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR								
			HENRY						HALL			4/23/82						7:30 P.M.								
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS.											
			Male			White			9-6-1897			84			MONTHS			DAYS								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10a. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK, TRADE, PROFESSION, OR BUSINESS)			12b. KIND OF BUSINESS OR INDUSTRY					
Virginia			U.S.A.						Wicomico			Salisbury			Peninsula General Hospital			Bakerman			Produce					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS														
Md.			Dorchester			Stanford			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			✓														
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME														
			Henry C. Hall									Camilla Moore														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
NO			228-14-5887						meningitis																	
2252			Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			(b)			DUE TO, OR AS A CONSEQUENCE OF																	
									DUE TO, OR AS A CONSEQUENCE OF																	
						(c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																										
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>														
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21f. HOW INJURY OCCURRED			21g. LOCATION STREET			21h. CITY OR TOWN			21i. COUNTY			21j. STATE								
21k. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21l. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21m. LOCATION																				
22a. I certify that (this hospital) attended the deceased from 3/25/82 to 4/23/82, that (I) (we) lost saw the deceased alive on 19_____, and that in (my) (our) (his) (her) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Rodney A. Wenrich, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/23/82														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 100 Power St. Salisbury Md. 21801																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4-26-1982			23c. NAME OF CEMETERY OR CREMATORIAL Service			23d. LOCATION CITY OR TOWN Dale Hall, Arundel Co. Md.			23e. COUNTY			23f. STATE											
Baria						Worthington Cemetery																				
24. FUNERAL DIRECTOR NAME Ruth			ADDRESS Templemore Ave. R.			25a. DATE REC'D. BY REGISTRAR APR 20 1982			25b. REGISTRAR'S SIGNATURE Ruth																	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8211070							
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR april 23, 1982									2b. HOUR 345 AM							
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			5 DATE OF BIRTH MONTH DAY YEAR II/14/38			6 AGE (IN YEARS LAST BIRTHDAY) 43 YRS			# UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS HOURS MIN					
3. SEX Female			4 RACE WHITE			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
7a. BIRTHPLACE COUNTRY MAINE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			13a. STATE MD.			13b. COUNTY WICOMICO			13c. CITY OR TOWN SALISBURY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 330 RIAWAKIN DR.		
10 CITY OR TOWN OF DEATH Salisbury			14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM A. CHESEBRA			15 MOTHER'S MAIDEN NAME RUTH CHESEBRA			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO			17 INFORMANT RONALD C. HARMON SALISBURY, MD.			ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1639 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost (b) (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			21g. DATE SIGNED 4/23/82										
22a. I certify that (I) (this hospital) attended the deceased from <u>4/22</u> , 19 <u>81</u> , to <u>4/23</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>4/22</u> , 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)(we)(did)(did not) view the body after death.																			
22b. SIGNATURE Dawn E. Councill MD			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 4/23/82										
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Dawn E. Councill MD			22g. ADDRESS 1300 S. Division St Salisbury MD 21801																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 4/23/82			23c. NAME OF CEMETERY OR CREMATORIAL DELMARVA CREMATORIAL			23d. LOCATION CITY OR TOWN LEWES DE			23e. COUNTY DE							
24. FUNERAL DIRECTOR NAME WILSON FUNERAL HOME			ADDRESS SALISBURY, MD.			25a. DATE REC'D. BY REGISTRAR APR 26 1982			25b. REGISTRAR'S SIGNATURE Dawn E. Councill										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
JOHN			HARRIS			APRIL 27 1982			11:30 A.M.					
3. SEX Male			4. RACE Black			5. DATE OF BIRTH MONTH DAY YEAR 7 5 1912			6. AGE (IN YEARS LAST BIRTHDAY) -69					
7a. BIRTHPLACE COUNTRY Md.			7b. CITIZEN OF WHAT COUNTRY? US			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico					
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.			13b. COUNTY Dorchester			13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
14. FATHER'S NAME FIRST MIDDLE LAST Eddie Harris			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elva N. Penny											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 214-07-7026			17. INFORMANT Annette Harris			ADDRESS 805 Fairmount Ave Cambridge, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Failure												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
5700 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												DUE TO, OR AS A CONSEQUENCE OF (b) Massive liver Necrosis		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Acute Tubular Necrosis, Pulmonary Tuberculosis												(c)		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 4/15/82 to 4/27/82, that (I) (we) last saw the deceased alive on 4/21/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE DEGREE BENITO S. CHAN MD		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENITO S. CHAN			22e. ADDRESS 577-40 Riverside Drive.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/27/82					
23a. BURIAL, CREMATION, REMOVAL (IF CEMETERY)			23b. DATE 5/1/82			23c. NAME OF CEMETERY OR CREMATORIAL Bethel			23d. LOCATION CITY OR TOWN Cambridge Dorchester, Md.					
24. FUNERAL DIRECTOR NAME ST. CLAIR FUNERAL HOME			ADDRESS 521 N. 15TH ST.			25a. DATE REC'D. BY REGISTRAR MAY 6 1982			25b. REGISTRAR'S SIGNATURE Dorothy Jean Nathan					
BP														

polution

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pollution

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8211072					
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			April 14 1982			3:58 AM		
CLARENCE									HAYWARD								
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS		
Male			Black			Month 9 Day 28 Year 17			64			MONTHS DAYS			HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS			MD.		
Md.			U.S.A.						Wicomico								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital									Labor					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Md.			Somerset			Pr. Anne						Rt. 3 Box 408					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
Edward			T.			Hayward			Della			Bivens					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			217-12-4278						Massive Right Sided Pneumonia								
7. 4860						DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost						DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
												<input type="checkbox"/> YES <input type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4/13/82 to 4/14/82, that (I) (we) lost sow the deceased alive on 4/14/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			BENITO S. CHAN			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			9/14/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			BENITO S. CHAN			22e. ADDRESS			544-2 Riverside Drive								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Burial			4-17-82			St Marks			Oaksville			APR 19 1982			Name: James H. III		
24. FUNERAL DIRECTOR NAME			ADDRESS														
Wm. H. James III			258 Church St. Pr. Anne, Md.														
DHMH - 16 50M 1/81 (VRA 15, 4)																	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW. 3. RETAIN PAGE 5 FOR YOUR FILE.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED. WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11073
REG. NO.

1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)						2a. DATE KNOWN OF ESTI- MATED		2b. MONTH DAY YEAR		2b. HOUR					
		CHARLES ROLAND HERRINGTON					<input checked="" type="checkbox"/> 4-10-82		19		3 P M						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD					
Male		White		9 16 09		72						4-10-82, 19					
7. BIRTHPLACE STATE OR CITY, PROVINCE, COUNTRY		8. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
PICTON, ONTARIO CANADA		USA		Wicomico		Salisbury						Peninsula General Hospital		RETIRED PHARMACIST		DRUGIST	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	
Md.		Worcester		Berlin		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 4, Box 32		EDWIN HERRINGTON						HARRIETT HOPKINS HERRINGTON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS					
NO		221-22-0774		WILLIAM SHOCKLEY, TAYLORVILLE, MD		IMMEDIATE CAUSE (a) Malnutrition 3320 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause</u> lost						DUE TO, OR AS A CONSEQUENCE OF (b) Parkinsonism DUE TO, OR AS A CONSEQUENCE OF (c)					
years						PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE						TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER						DATE SIGNED 4-13-82					
EXAMINER'S NAME (TYPE OR PRINT)		Earl L. Royer, M.D.						ADDRESS 409 Camden Ave., Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL SUNSET MEMORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE							
BURIAL		4/14/82				BERLIN		WORCESTER		MD							
24. FUNERAL DIRECTOR NAME <u>Burke's Funeral Home</u> ADDRESS <u>Berlin, Md.</u>						25a. DATE REC'D. BY REGISTRAR APR 19 1982						25b. REGISTRAR'S SIGNATURE <u>James J. Martin</u>					

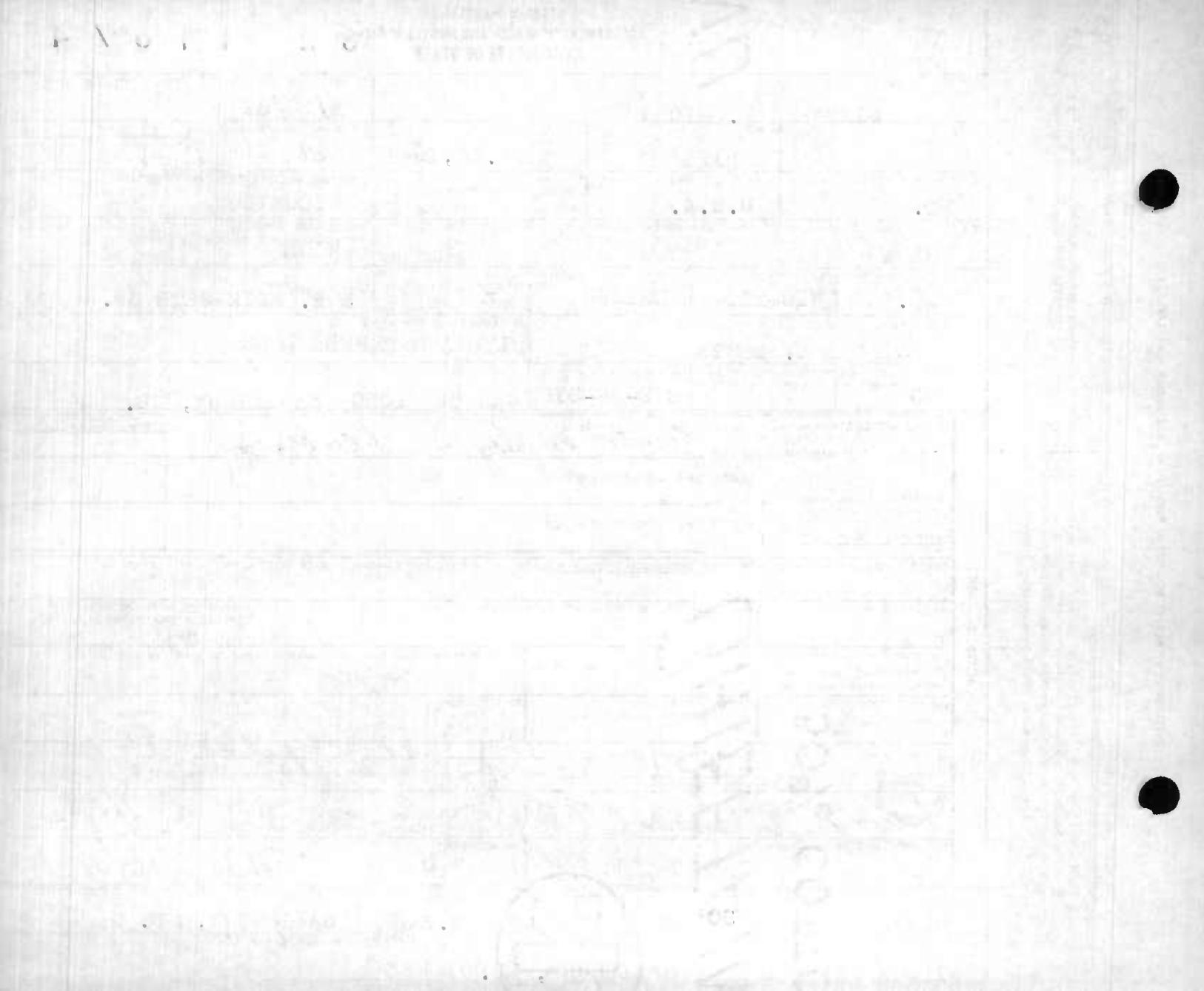
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or after a traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8211074											
												REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR											
DIANNE M. HICKS								4/28/82															
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 30, 1944				6. AGE (IN YEARS LAST BIRTHDAY)				M IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO				10. CITY OR TOWN OF DEATH DELMAR		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AT HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE				12b. KIND OF BUSINESS OR INDUSTRY MD.	
13a. STATE MD.		13b. COUNTY WICOMICO		13c. CITY OR TOWN DELMAR		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3 E. ELIZABETH ST.															
14. FATHER'S NAME FIRST MIDDLE LAST RAYMOND S. LEWIS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LYDIA MARSHELL LONG																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 219-34-3183				17. INFORMANT CARROLL LONG SALISBURY, MD.				ADDRESS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myelogenous Leukemia</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
2050 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b), DUE TO, OR AS A CONSEQUENCE OF (c), DUE TO, OR AS A CONSEQUENCE OF																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that (I) (this hospital) attended the deceased from <i>May 19 81</i> to <i>Apr 28 82</i> , that (I) (we) last saw the deceased alive on <i>Apr 21 81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <i>David E. Cowall MD</i> DEGREE																							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID E. COWALL, M.D.		22e. ADDRESS 1300 S. Division St. Salisbury, MD 21801				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22f. DATE SIGNED 4/28/82													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/30/82		23c. NAME OF CEMETERY OR CREMATORIAL WICOMICO MEM. PARK				23d. LOCATION CITY OR TOWN SALISBURY, MD				23e. COUNTY WICOMICO											
24. FUNERAL DIRECTOR NAME WILSON FUNERAL HOME SALISBURY, MD.						25a. DATE REC'D. BY REGISTRAR 4/28/82				25b. REGISTRAR'S SIGNATURE <i>John Denney</i>													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 1 0 7 5					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Eunice L									HORSEY			APRIL 6, 1982	35			35	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS		
Female			Black			MONTH 9 - DAY 23 - YEAR 1914			68			MONTHS			DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland			U. S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Wicomico								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Salisbury			Peninsula General Hospital			Domestic											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS					
Maryland			Wicomico			Hebron						302 Chestnut St.					
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.					
Brooks						Ford			Addie			215-26-2700					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS					
No															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4100						DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Heart Disease											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/6/82</u> to <u>4/6/82</u> , that (I) (we) last saw the deceased live on <u>1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																	
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
Burial			4-9-82			Spring Hill Garden			Hebron			Wicomico Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			25a. DATE REC'D. BY REGISTRAR					
24. FUNERAL DIRECTOR NAME			ADDRESS												25b. REGISTRAR'S SIGNATURE		
Clinton F. Stewart West Rd. Salis. Md.															Zenas Van Wart		
DHMH-16 50M 1/81 (VRA 15, 4)																	

on board

Indonesian Research Institute

Yogyakarta

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Indonesian Research Institute

abt. 2

BB 1961 23-0-1

Indonesian Research Institute

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEEDED, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR OWN USE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 11076						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. MONTH DAY YEAR			
Richard James Jones, Jr.												<input checked="" type="checkbox"/> 4-20-82			6:23P M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. MONTH DAY YEAR	
Male		White		1/17/1918			64 yrs.							April 20 1982			11 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		USA		<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED			WICOMICO											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital										Asst. Manager			Food Store			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
Maryland		Wicomico		Salisbury						Pemberton Drive								
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME														
Richard James		Jones, Sr.		Manie Ellen														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS											
No		213-18-5100		(Personal Rep.)			George White, 132 E. Main St., Salisbury											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) Bullet Wound of Brain 9554 Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost.												minutes						
DUE TO, OR AS A CONSEQUENCE OF																		
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																		
(c) _____																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										2d. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input type="checkbox"/> MONTH DAY YEAR 5:40 PM 4-20-82			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			Self-inflicted gunshot wound.										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET Box 171, Willards, Wicomico CITY OR TOWN COUNTY Pemberton Dr., Salisbury, Wic., Md.			STATE										
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>			and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY)			M.D. Deputy			MEDICAL EXAMINER				DATE SIGNED 4/22/82						
EXAMINER'S NAME (TYPE OR PRINT)		Earl L. Royer, M.D.			ADDRESS 409 Camden Ave., Salisbury, Maryland													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			CITY OR TOWN		COUNTY STATE						
Burial		4/23/82		Wicomico Memorial Park			Salisbury, Wicomico, Maryland			Salisbury, Wicomico, Maryland								
24 FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
HOLLOWAY FUNERAL HOME, Salisbury, Maryland					APR 27 1982			Frances Jean Kesten										

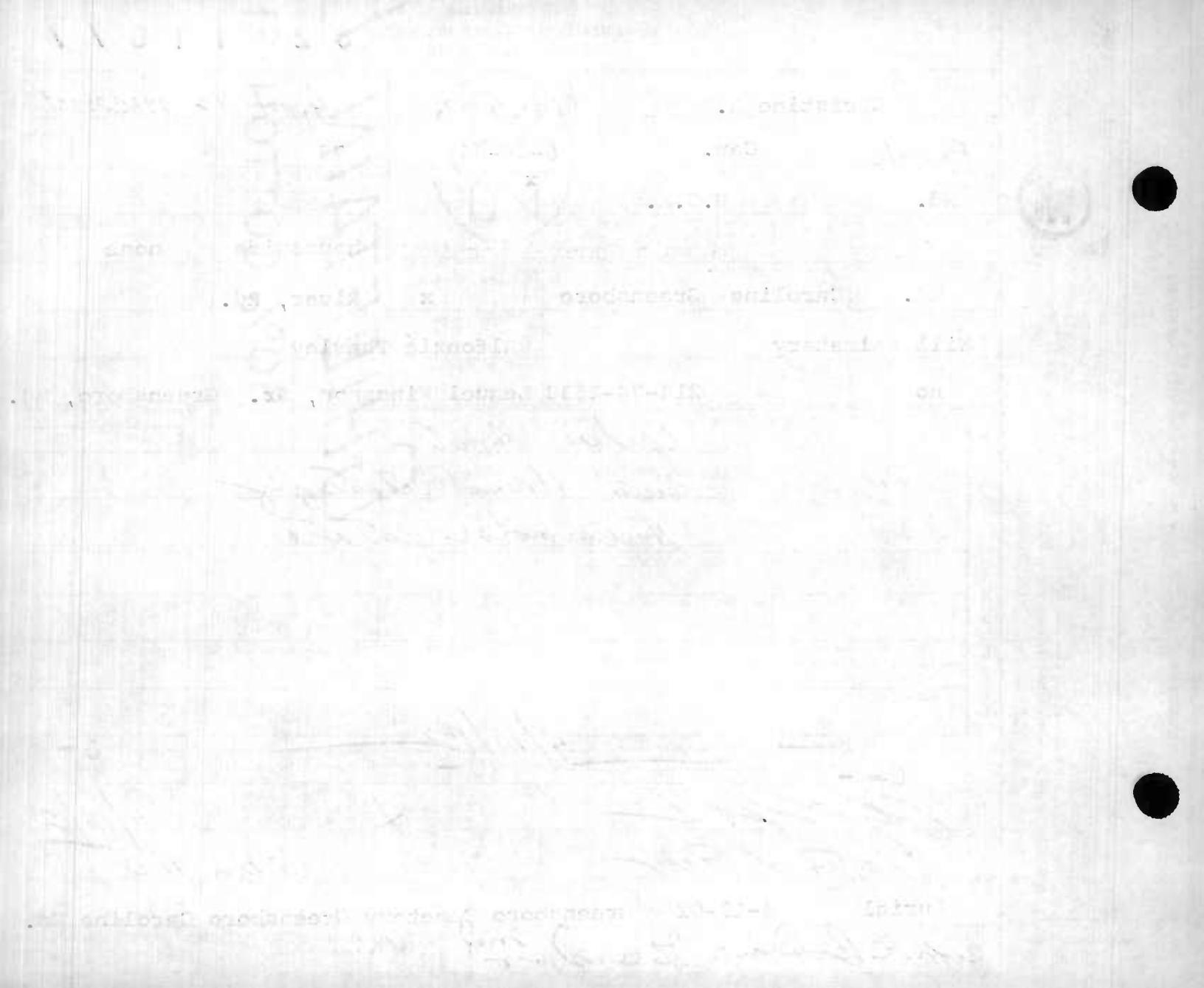
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in in the presence of the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical certificate should be detached and sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8211077					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR			
Christine A.			Kinnaman			April 16 1982			16	16	1982	2:35 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Female		Cau.		6-24-06			75			YRS.					
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		U.S.A.						Wicomico			MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Salisbury		Peninsula General Hospital						housewife			none				
13a. STATE Md.		13b. COUNTY Caroline		13c. CITY OR TOWN Greensboro		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS River, Rd.						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST				
Will Palmatary						Alfonzie Thawley									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-74-2530			17. INFORMANT			ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for 18, 1b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		214-74-2530			Cardiac Arrest						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
2760 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if lost		b) <i>Acute Abdominal cramping</i>			DUE TO, OR AS A CONSEQUENCE OF										
		c) <i>Hypoglycemic state</i>			DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (1) I have attended the deceased from saw the deceased alive on above date and (2) did not view the body after death.		22b. DEGREE			22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Clayton L. Root		22f. ADDRESS Box 99			22g. ADDRESS Salisbury MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-19-82		23c. NAME OF CEMETERY OR CREMATORIUM Greensboro Cemetery			23d. LOCATION CITY OR TOWN Greensboro			23e. COUNTY Caroline		STATE Md.			
24. FUNERAL DIRECTOR John E. Bowditch Greensboro		25a. DATE OF DEATH APR 22 1982			25b. PLACE OF DEATH Greensboro			25c. CAUSE OF DEATH Hypoglycemic state							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please type or print.

M

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH82 11078
REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
NORMA STAUB			LAW			APRIL	5	1982	3 P.M.	3 P.M.	
3 SEX		4 RACE	5 DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
F		W	MONTH 8 DAY 14, 1890 YEAR			91			MONTHS	YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
MD		USA						Wicomico			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital			NONE						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MD		WORCESTER		BERKIN				103 BROAD ST.			
14 FATHER'S NAME		15 MOTHER'S M AIDEN NAME									
FIRST GEORGE R.		LAST STAUB			FIRST MARY			MIDDLE FINEYFRICK LAST MARTHA ELLEN MASSEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS			
NO		220 46 0122									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <i>Coronary Congestive failure</i>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
4149											
DUE TO, OR AS A CONSEQUENCE OF (b): <i>Coronary heart Disease</i>											
DUE TO, OR AS A CONSEQUENCE OF (c):											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(b)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED. (ENTER NATURE OF INJURY IN ITEM 21, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED: WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN COUNTY STATE				
22a. I certify that (i) this hospital attended the deceased from <i>4/1/82</i> to <i>4/1/82</i> , that (ii) we last saw the deceased alive on <i>4/1/82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) did (did not) view the body after death.											
22b. SIGNATURE		22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED			
J. L. Raffetto											
22f. PHYSICIAN'S NAME (TYPE OR PRINT)		22g. ADDRESS									
J. L. Raffetto		R617									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ODD FELLOWS			23d. LOCATION CITY OR TOWN			23e. STATE	
BURIAL		4/8/82		ODD FELLOWS			BISHOPSVILLE, WO., MD.			COUNTY STATE	
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Norma A. Burbage		8 WILLIAMS ST. BERKIN MD 21001			1982/4/8/82			Franee Jean Hart			

BP

so it too is

Lepturus leptocephalus

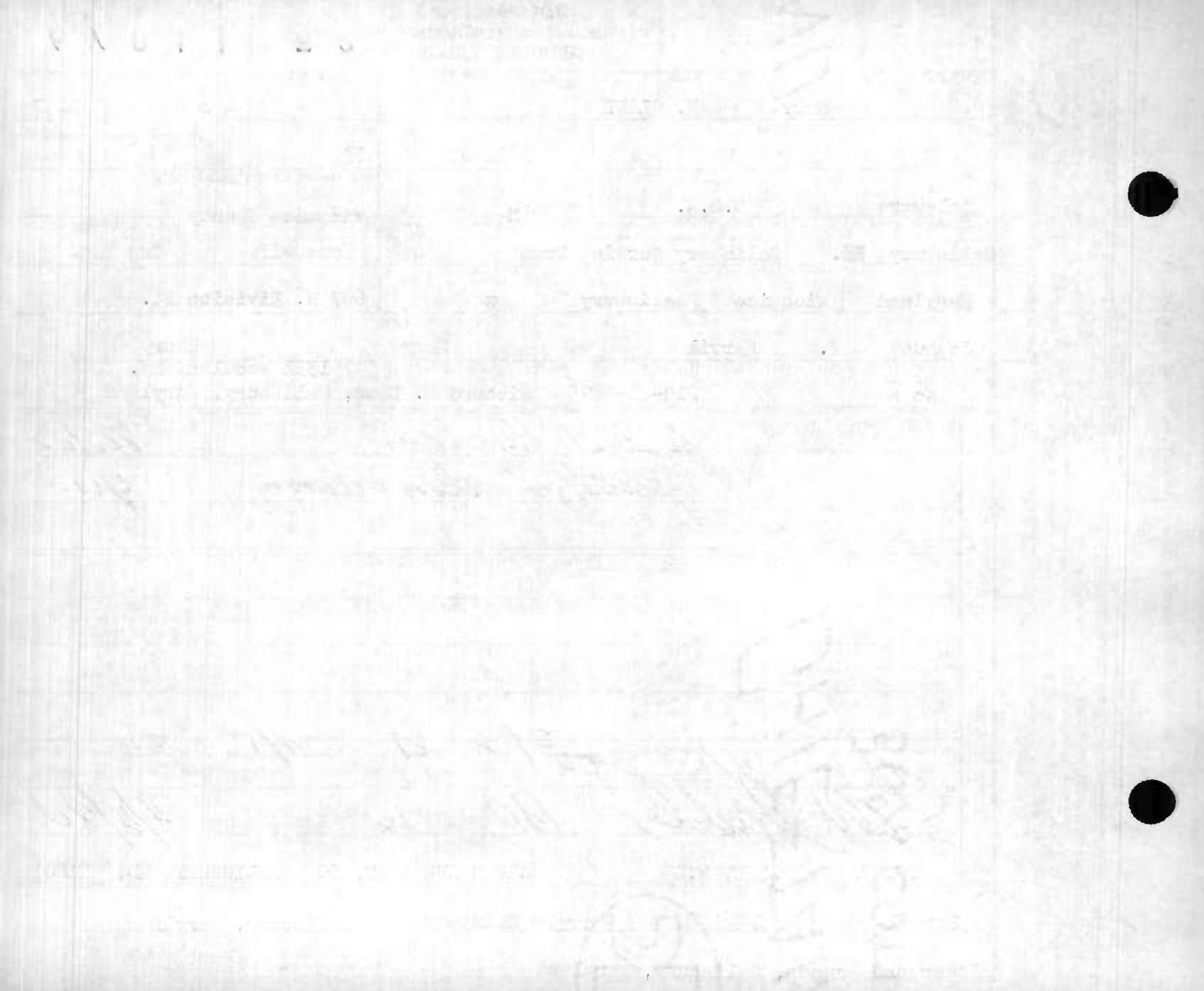
seafloor

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified on once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 1 0 7 9	
1 - FOR STATE REGISTRAR											REG. NO.		
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Mary			M.	Laws		4-5-82						3:30 P M	
3. SEX			4. RACE			5. DATE OF BIRTH			16. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
F			W			MONTH DAY YEAR			79	MONTHS	YEARS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Delaware			U.S.A.						Wicomico County MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury, Md.			Salisbury Nursing Home			Housewife			Own Home				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
Maryland			Wicomico		Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			607 N. Division St.			
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.				
Joshua			H. Marvil			Mary			17. INFORMANT				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			132 ADD. Woodland Rd.				
No			214-28-7875			Richard M. Laws, Salisbury, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4340 <i>Decline of heart</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>generalized arteriosclerosis</i>												70s - yes.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <i>3/2/81</i> to <i>4/15/82</i> , that (I) (we) last saw the deceased alive on <i>3/2/81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did not) (Did not) view the body after death.												22b. DATE SIGNED <i>4/6/82</i>	
22c. SIGNATURE <i>Earl M. Beardsley M.D.</i>			22d. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS CIVIC AVE & RT. 50, SALISBURY, MD. 21801							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 5/9/1982			23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery			23d. LOCATION CITY OR TOWN Salisbury, Maryland			23e. COUNTY STATE	
24. FUNERAL DIRECTOR NAME Baker and Bounds, Salisbury, Maryland			ADDRESS			25. DATE REC'D. BY REGISTRAR APR 12 1982			25e. REGISTRAR'S SIGNATURE <i>James J. Baker</i>				

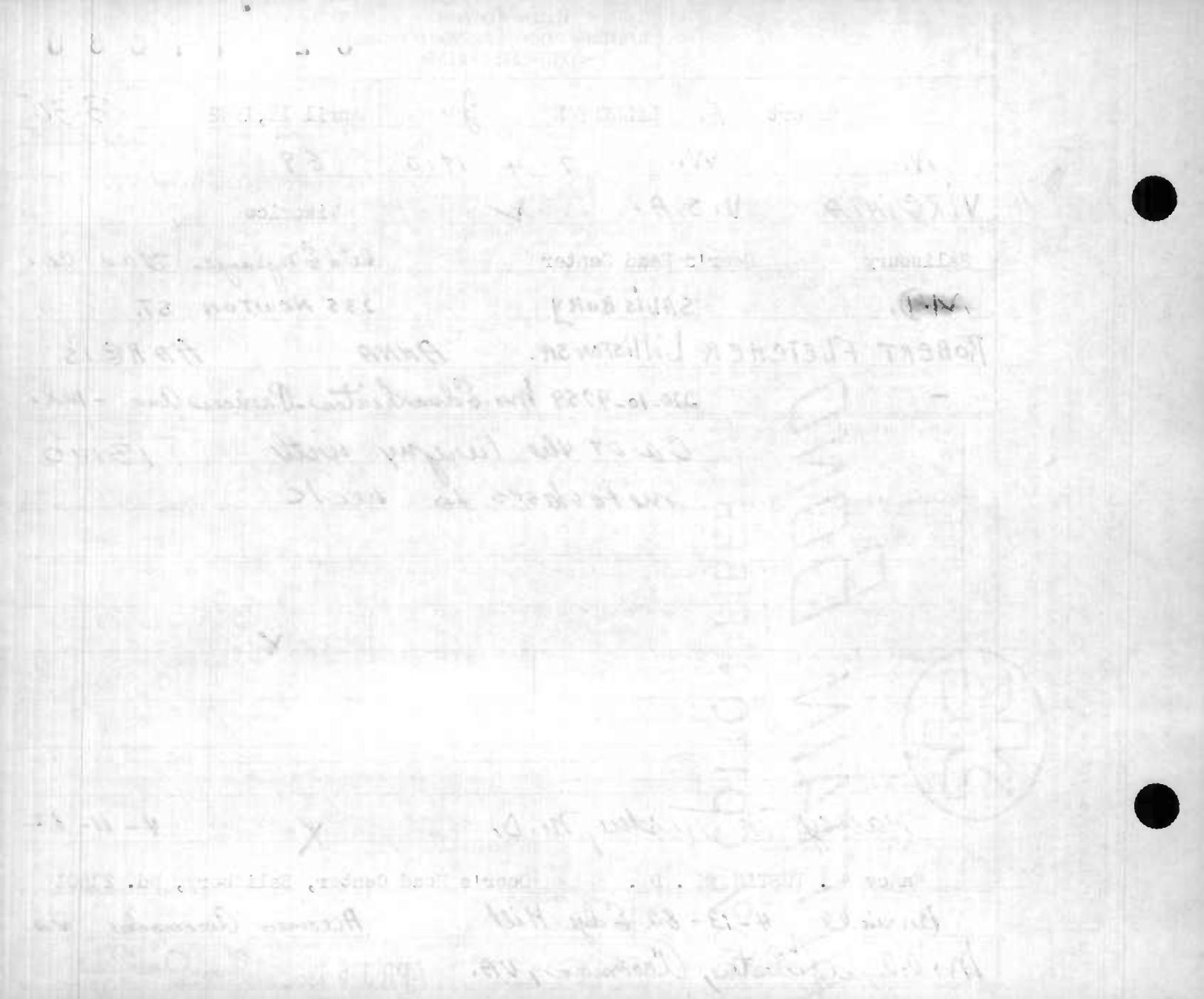


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	1	0	8	0		
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Robert F. LILLISTON Jr.									Jr.			April 11, 1982						3:30 ^{PM}		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH		
M.			W.			7 4 1912			69			VIRGINIA			U.S.A.			Wicomico		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (PE OF WORK OR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Salisbury			Deer's Head Center															Retail Employment		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
MD.			Wic			SALISBURY			YES <input type="checkbox"/> NO <input type="checkbox"/>			235 NEWTON ST.								
14. FATHER'S NAME			FIRST MIDDLE			15. MOTHER'S MAIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		
ROBERT FLETCHER			LILLISTON SR.			ANNA			-			220-10-9759			Mrs. Edna Linton - Princess Anne - Md.			Ca of the larynx with metastases to neck		
16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			18 NOV																	
18d. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			18 NOV																	
16b. DUE TO, OR AS A CONSEQUENCE OF (b)			18 NOV																	
16c. DUE TO, OR AS A CONSEQUENCE OF (c)			18 NOV																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED								
22b. SIGNATURE Nancy W. TUSTIN, M.D.												22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>														
Nancy W. TUSTIN M.D.									4-11-82											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL EDGE HILL			23d. LOCATION CITY OR TOWN Accomac			COUNTY STATE Accomac VA.								
Burial			4-13-82																	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Madelyn Lilliston, Accomac, VA.						APR 16 1982			Franie Janie March											



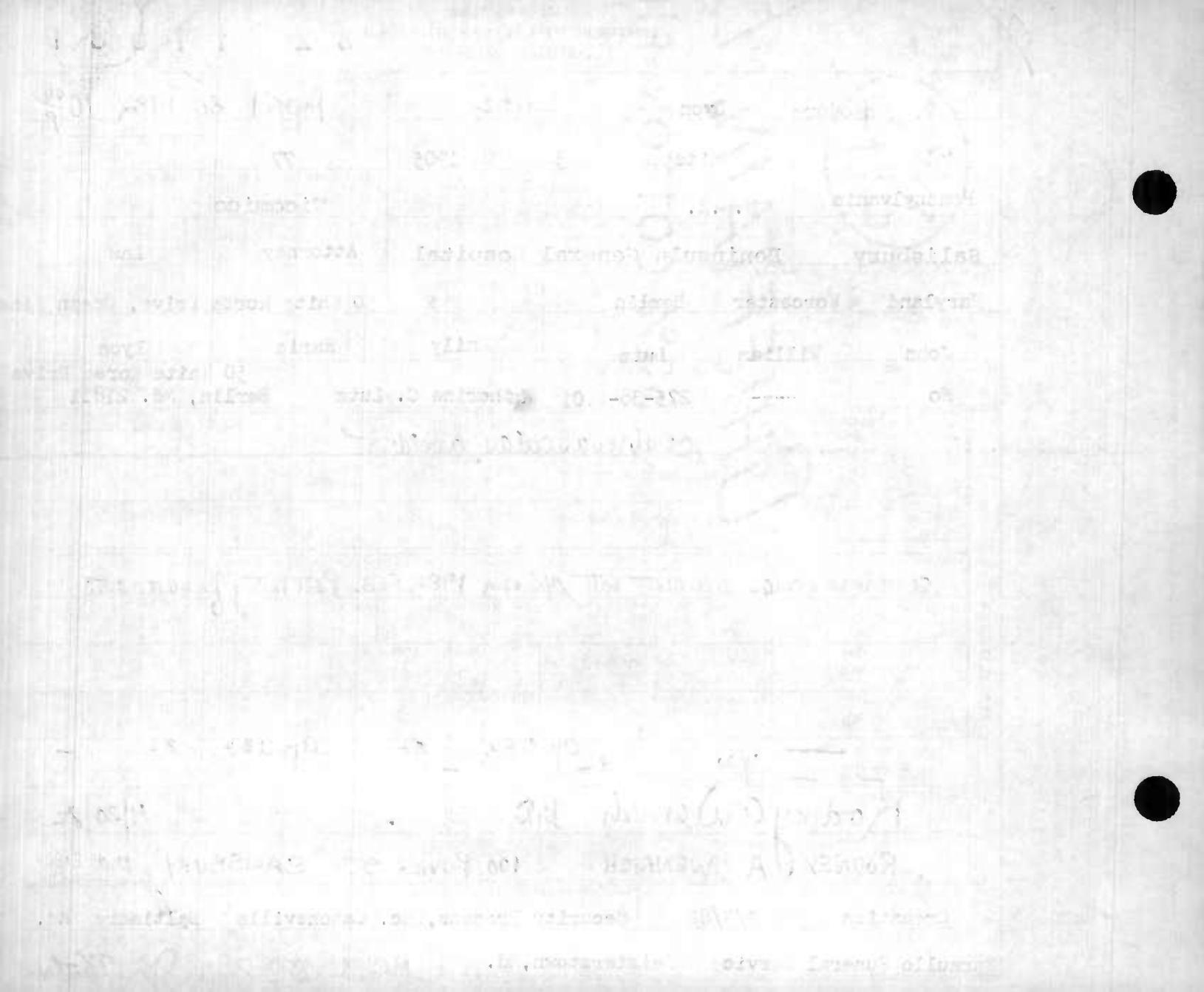
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, Page 3 should be detached for use as the burial and Mental Hygiene permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8211081														
											REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR								
Theodore			Lyon			Lutz						April 30 1982			10	40	PM									
3. SEX			4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 2 yrs									
Male			White			MONTH 3			DAY 9			YEAR 1905			77		YRS									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.											
Pennsylvania			U.S.A.									Wicomico														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																	
Salisbury			Peninsula General Hospital			Attorney			Law																	
13a. STATE 13b. COUNTY												13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Maryland			Worcester			Berlin			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			50 White Horse Drive, Ocean Pine														
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST											
John			William			Lutz			Emily			Marie			Lyon											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
No			----			275-38-1101			Katherine C. Lutz			50 White Horse Drive Berlin, Md. 21811														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												4360														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												cerebrovascular accident														
DUE TO, OR AS A CONSEQUENCE OF (b)																										
DUE TO, OR AS A CONSEQUENCE OF (c)																										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																	
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)																				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE												
22a. I certify that (I) <input type="checkbox"/> attended the deceased from April 26, 1982, to April 30, 1982, that (I) <input type="checkbox"/> lost saw the deceased alive on 4/30/82, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.																										
22b. SIGNATURE			RODNEY A. WENRICH			DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			RODNEY A. WENRICH			22e. ADDRESS										4/30/82										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE												
Cremation			5/3/82			Security Process, Inc.			Catonsville			Baltimore		Md.												
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																	
Marzullo Funeral Service			Reisterstown, Md.			MAY 3 1982			James J. Wether																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Form may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	1	0	8	2		
												REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
RUSSELL			E.			LYNCH						April 2, 1982						8:10 A.M.		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.						
Male			White			OCT. 15, 1915			66			YRS.		MONTHS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
DELAWARE			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			WICOMICO											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Salisbury			Beer's Head Center						RETIRED MARINE ENG.											
13a. STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS											
DELAWARE			SUSSEX			FRANKFORD			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			R.D.1, BOX 99								
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST					
EBE W. LYNCH									LUETTA R. LYNCH											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS											
NO			165-12-2400			MARJORIE S. LYNCH - WIFE														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
IMMEDIATE CAUSE (a) <u>Carcinoma of pharynx & neck</u>																				
1490 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																				
DUE TO, OR AS A CONSEQUENCE OF (b) _____																				
DUE TO, OR AS A CONSEQUENCE OF (c) _____																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>March 31, 1982</u> to <u>April 2, 1982</u> , that (I) (we) last saw the deceased alive on <u>April 2, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.																				
22b. SIGNATURE <u>E. P. Ritchings, M.D.</u>												DEGREE								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. P. Ritchings, M.D.												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22e. ADDRESS Deer's Head Center, Salisbury, MD 21801												22e. DATE SIGNED <u>4/2/82</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN											
BURIAL			4-5-82			ST. GEORGE'S CEM.			CLARKSVILLE, SUSSEX, DE.											
24. FUNERAL DIRECTOR NAME <u>George Mobley</u>			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>James J. Parker</u>														
			APR 6 1982																	

With kind regards 2001.0. 89A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 1 0 8 3			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			MARSH			APRIL 12, 1982			2b. HOUR 6:45 AM
DONALD C.			C.			MARSH			MARSH			APRIL 12, 1982			6:45 AM
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH 12 DAY 9 YEAR 51			6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS.			7. IF UNDER 1 YEAR MONTHS 0 DAYS HOURS 0 MIN.			8. IF UNDER 24 HRS MONTHS 0 DAYS HOURS 0 MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			10. CITY OR TOWN OF DEATH Salisbury			MD.
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter			12b. KIND OF BUSINESS OR INDUSTRY Ship repair			13a. STREET ADDRESS Rural			13b. CITY OR TOWN Rhodes Point			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland			13c. COUNTY Somerset			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rural			14. FATHER'S NAME FIRST MIDDLE LAST Leon Marsh			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olevia Ruth Marsh
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216-64-8789			17. INFORMANT Charlie D. Evans - Ewell, MD 21824			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Liver failure</i>			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days			
5712 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (b) <i>Gastrointestinal Bleeding (varicose)</i> 5 days			DUE TO, OR AS A CONSEQUENCE OF (c) <i>Laennec's Cirrhosis</i> 2 years									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>4/11/82</i> , to <i>4/12/82</i> , that (I) (we) last saw the deceased alive on <i>4/11/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.															
22b. SIGNATURE <i>George Galifianakis</i>			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 4/12/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Galifianakis, M.D.			22e. ADDRESS Medical Center - Salisbury, MD 21801												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/15/82			23c. NAME OF CEMETERY OR CREMATORIAL Rhodes Point Cemetery			23d. LOCATION CITY OR TOWN Rhodes Point - Somerset - MD			COUNTY STATE			
24. FUNERAL DIRECTOR NAME Bradshaw & Sons			25a. ADDRESS Crisfield, MD 21817			25b. DATE REC'D. BY REGISTRAR APR 15 1982			25c. REGISTRAR'S SIGNATURE <i>Theresa Jan Martin</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

ITEMS 13a-e PER PHONE 4/16/82 DATE STATE OF MARYLAND										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR			REG. NO.														
LEKO			JASMINE McELVY			April 2, 1982			APR 2 1982			3:55P			8211084														
3. SEX <i>Female</i>			4. RACE <i>Black</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>April 2 1982</i>			6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			10b. KIND OF BUSINESS OR INDUSTRY MD.														
10. CITY OR TOWN OF DEATH <i>Salisbury</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>			13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.			13c. COUNTY Wicomico			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 109 2nd St. Apt. 3														
14. FATHER'S NAME FIRST <i>Edward</i>			MIDDLE <i>Lee Landers</i>			LAST <i>Mactry</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Felicia</i>			MIDDLE <i>Eugenia</i>			LAST <i>Davis</i>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO.			17. INFORMANT																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>7651</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>35 hrs 28 vox</i>																			
DUE TO, OR AS A CONSEQUENCE OF (b)																													
DUE TO, OR AS A CONSEQUENCE OF (c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
22a. I certify that (1) this hospital attended the deceased from <i>4/2 1982</i> to <i>4/2 1982</i> , that (2) (we) last saw the deceased alive on <i>4/2 1982</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <i>Alfred C. Kolls</i>			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>4/6/82</i>																				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ALFRED C. KOLLS, M.D.</i>			22e. ADDRESS <i>MEDICAL CENTER, SALISBURY, MD</i>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>			23b. DATE <i>4/6/82</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Peninsula General Hospital</i>			23d. LOCATION CITY OR TOWN <i>Salisbury</i>			23e. COUNTY STATE <i>Wicomico Md</i>											
24. FUNERAL DIRECTOR NAME <i>Virginia Layfield</i>			ADDRESS <i>Peninsula General Hospital</i>			25. MEDICAL RECORDS DUE BY REGISTRAR <i>APR 12 1982</i>			25. REGISTRAR'S SIGNATURE <i>Virginia Layfield</i>																				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2	1 1 0 8 5	REG. NO.												
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
			Willis Lein (Lee)									MILLER			APRIL 12 1982			12	15	1982	4 15					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White			MONTH DAY YEAR			78			Pennsylvania			USA			Wicomico			MONTHS DAYS		HOURS MIN.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Salisbury			Peninsula General Hospital			Sheet Metal Laborer			Maryland			Wicomico			Salisbury			Salisbury			YES <input type="checkbox"/> NO <input type="checkbox"/>			825 S. Division Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:			19. DATE OF OPERATION			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
John			Laura			NO			172-05-5563			Mrs. Edna T. Miller (wife) same as			Multiple Myeloma			2030			YES <input type="checkbox"/> NO <input type="checkbox"/>			ADDRESS		
IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I) <input type="checkbox"/> (the hospital) attended the deceased from saw the deceased alive on 4/11 19 19 <input type="checkbox"/> and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death.			22b. SIGNATURE Joseph N. Grasso			22c. DATE SIGNED 4/12/82			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph N. Grasso			22e. ADDRESS 1300 S. Division St			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/14/82			23c. NAME OF CEMETERY OR CREMATORIAL Allen Cemetery			23d. LOCATION CITY OR TOWN Allen, Wicomico, Maryland		
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.			25a. DATE REC'D. BY REGISTRAR APR 14 1982			25b. REGISTRAR'S SIGNATURE Frances Jean Kithen																				

06404

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or sent.

Item 23b g567 5/26/82 gj

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 0 8 6

REG. NO.

1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR										2b. HOUR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.			
1 DECEASED NAME (TYPE OR PRINT)			FIRST Walter			MIDDLE MOLOCK			LAST Jr.			April 18, 1982			2 30 2 pm M	
3 SEX Male			4 RACE Negro			5 DATE OF BIRTH MONTH DAY YEAR 10-19-1903			6. AGE (IN YEARS LAST BIRTHDAY) 78 yrs							
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico							
10 CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md			13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 901 Pine							
14. FATHER'S NAME FIRST Walter			LAST Molock Sr.			15. MOTHER'S MAIDEN NAME Rosy									LAST Bowen	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. No 214-07-8750			17. INFORMANT (SISTER) Normi Land			ADDRESS 901 Pine St., Camb., Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>gram negative Septicemia</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Pneumonia & Urinary infection</i>																
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus</i>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>M. Shrestha</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4-19-82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Shrestha, M.D.			22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-22-82			23c. NAME OF CEMETERY OR CREMATORIAL Bethel AME Cem			23d. LOCATION CITY OR TOWN Cambridge, Dor.			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME L.H. Boardley			ADDRESS Cambridge, Maryland			25a. DATE OF DEATH APR 21 1982			25b. NAME OF MARYLAND REGISTRAR Frances Jean Hartman							

Size of class 100 total

of FOR-PLA total

classroom x 100 total

periods total time spent

only 100 x 100 total

new 100 x 100 total

(RET'D)

classroom only 100 total 100 hours

new 100 x 100 total

Size

of class

100

total

100

total

new 100 x 100 total

new 100 x 100 total

new 100 x 100 total

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be called in to examine the body.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 1 0 8 7							
											REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
Alton Mace Morris						April 25, 1982						6:45 P.M.							
SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male		White		MONTH DAY YEAR Nov. 18, 1919			62			MONTHS	YEARS	HOURS	MIN.						
7. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.									
Maryland		U.S.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Wicomico												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Salisbury		Peninsula General Hospital			Utility Employee														
13a. STATE Md.												13b. COUNTY Cambridge		13c. CITY OR TOWN Dor.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 414 Atlantic Ave.,	
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST										
Alva			Troy	Morris	Nedith			Alverta	Frazier										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS										
YES			1941-1945 214-07-9636			Mary G. Morris, Cambridge, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for Part I and II) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH							
1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												DUE TO, OR AS A CONSEQUENCE OF (b) Barium							
												DUE TO, OR AS A CONSEQUENCE OF (c) Psychosis							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION 1/21/82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Esophagus			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR: A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED? (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)													
22a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21c. LOCATION STREET			CITY OR TOWN	COUNTY	STATE								
22a. I certify that (i) this hospital attended the deceased from 11/18/81 to 11/18/82, and that in [my] [our] opinion death occurred on the date and hour and from the causes stated above. (ii) (we) did not view the body after death.												21c. CITY OR TOWN							
22b. SIGNATURE Richard E. Hughes, MD			22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 4/27/82										
22e. ADDRESS 7 Medical Center, Salisbury, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr. 28, 1982			23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park, Cambridge			23d. LOCATION CITY OR TOWN			COUNTY							
24. FUNERAL DIRECTOR NAME Thomas Funeral Home, Cambridge, Md.			25a. DATE REC'D. BY REGISTRAR/RECEIPT DATE MAY 3 1982																

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death is reported by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	1	0	8	8
												REG. NO.						
1 - FOR STATE REGISTRAR			2a DATE OF DEATH			MONTH		DAY		YEAR		2b HOUR						
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST		4-30-1982			11:05 a					
WILLIAM ALFRED NIBLETT																		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS						
Male			White			Nov. 20, 1900			81			YRS						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Delaware			USA						WICOMICO									
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY									
SALISBURY			SALISBURY NURSING HOME			Inspector			Mfg. Co.									
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Maryland			Wicomico			Salisbury						608 Homer Street						
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE						
(unknown)									Sally			Ella Niblett						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			13						
NO			214-10-8480			Mrs. Ethel L. Niblett (wife)			same as 13									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>carcinoma of lung - metastasis</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1981			
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.																		
DUE TO, OR AS A CONSEQUENCE OF (b)																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
YES <input type="checkbox"/> NO <input type="checkbox"/>						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)												
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a I certify that (I) this hospital attended the deceased from since the deceased died on <i>4/14/82</i> to <i>4/14/82</i> , 1981, to <i>4/14/82</i> , 1982, that (I) (we) lost the deceased alive on <i>4/14/82</i> , 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. All the (I) (we) (did not) (did not) know the body after death.																		
22b SIGNATURE <i>John Beardsley</i>			DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED <i>4/14/82</i>									
22d PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, M.D.			22e ADDRESS U.S. 50 AT CIVIC AVE., SALISBURY, MD. 21801															
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 5/3/82			23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery			23d. LOCATION CITY OR TOWN Salisbury			COUNTY Wic.						
Burial																		
24 FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR MAY 4 1982			25b. REGISTRAR'S SIGNATURE <i>James J. Martin</i>									

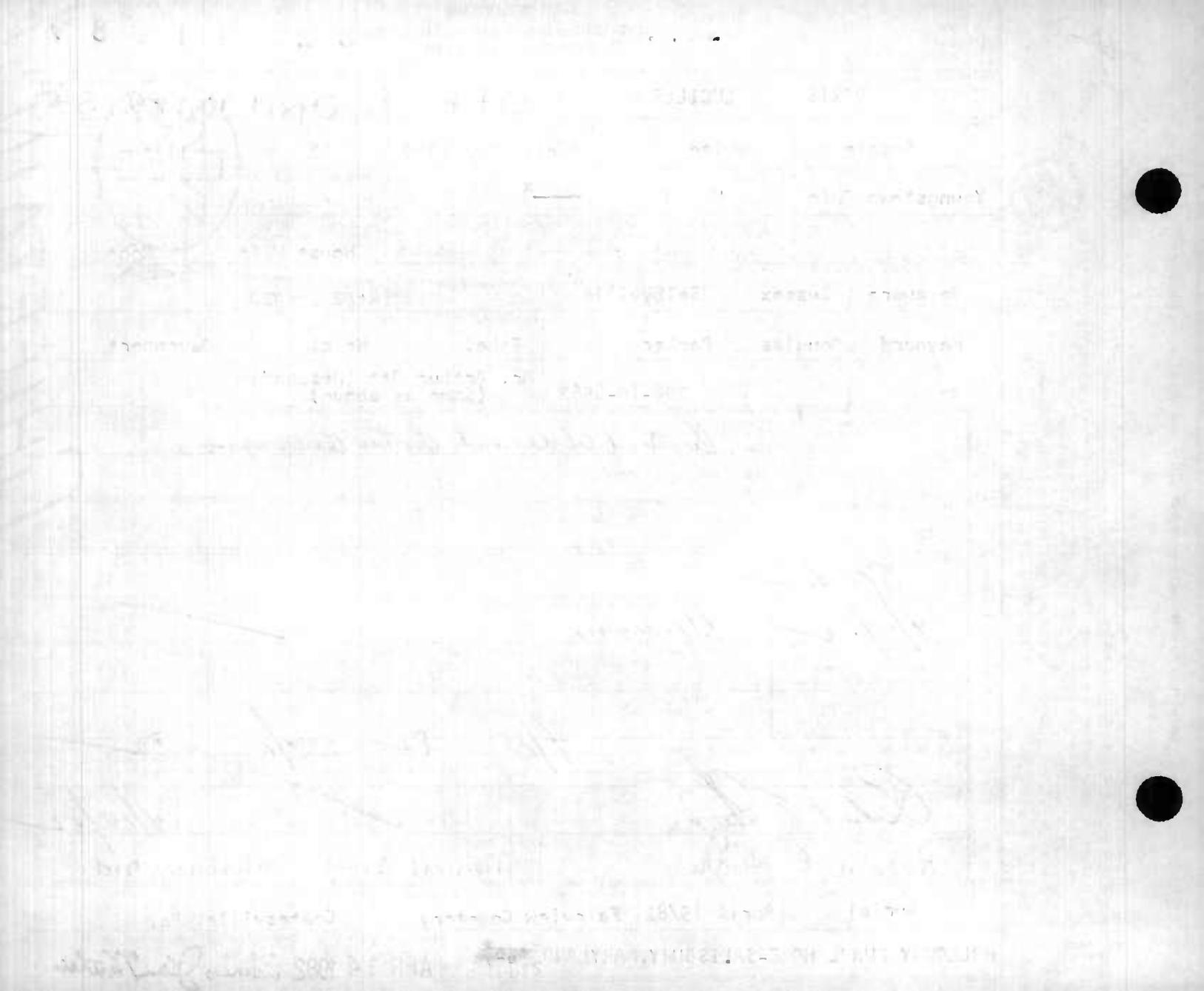
BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8211089			
												REG. NO.			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH			DAY		YEAR		2b. HOUR		
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			April 10, 1982			10		1982		3:22 P.M.		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH April DAY 30 YEAR 1919			6. AGE (IN YEARS LAST BIRTHDAY) 62			IF UNDER 1 YEAR MONTHS 11		IF UNDER 24 HRS DAYS 10	
7a. BIRTHPLACE (COUNTRY) Youngstown Ohio			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			MD.			
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife			12b. KIND OF BUSINESS OR INDUSTRY None						
13a. STATE Delaware			13b. COUNTY Sussex			13c. CITY OR TOWN Selbyville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Rt#2 Box#20			
14. FATHER'S NAME FIRST MIDDLE LAST Maynard Douglas Parker			15. MOTHER'S MAIDEN NAME Ethel Neici			16. SOCIAL SECURITY NO. 200-10-6562			17. INFORMANT Mr. Arthur Ott (Husband) (Same as above)			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			18b. SOCIAL SECURITY NO. 200-10-6562			18c. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>ruptured abdominal aortic aneurysm</i>									
4413 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			18d. DUE TO, OR AS A CONSEQUENCE OF (b)			18e. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Shock</i>															
19a. DATE OF OPERATION 4/10/82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Neuropathy</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.												22b. DATE SIGNED 4/10/82			
22b. SIGNATURE <i>Richard E. Hughes</i>												DEGREE			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard E. Hughes			22e. ADDRESS Medical Center Salisburg, Md.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED 4/10/82						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 15/82			23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery			23d. LOCATION CITY OR TOWN Coatesville, Pa.			23e. COUNTY			
24. FUNERAL DIRECTOR HOLLOWAY FUN'N HOME-SALISBURY, MARYLAND 21801												25a. DATE REC'D. BY REGISTRAR APR 14 1982			
												25b. REGISTRAR'S SIGNATURE <i>Frances Jean Wether</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 0 9 0			
										REG. NO.			
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Marie Ella Owens						April 12 1982			5:40 P.M.	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS	
Female			White			July 19, 1913			68			IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD	
Pittsville, Md.			USA						WICOMICO				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING-LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
SALISBURY			PENINSULA GENERAL HOSPITAL			Housewife			none				
13a. STATE Maryland			13c. COUNTY Wicomico			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Rt. 1, Box 319C				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Nelson J. Ruark			Harriette Brown										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO			219-07-6306			Mr. Robert N. Owens (son) same as 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4140 heart failure													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { DUE TO, OR AS A CONSEQUENCE OF (b) arterioclerotic heart disease													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a lung carcinoma													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>Mar. 22, 1982</u> to <u>April 12, 1982</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>April 12, 1982</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE Rodney A. Wenrich			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/12/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RODNEY A. WENRICH			22e. ADDRESS 100 POWER ST SALISBURY MD. 21801										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/15/82			23c. NAME OF CEMETERY OR CREMATORIAL Springhill Memory Gardens, Salisbury, Wic., Maryland			23d. LOCATION CITY OR TOWN				
24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 19 1982 Charles J. [Signature]			REGISTRAR				
BP													
DHMH - 16 50M 1 / 81 (VRA 15, 4)													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

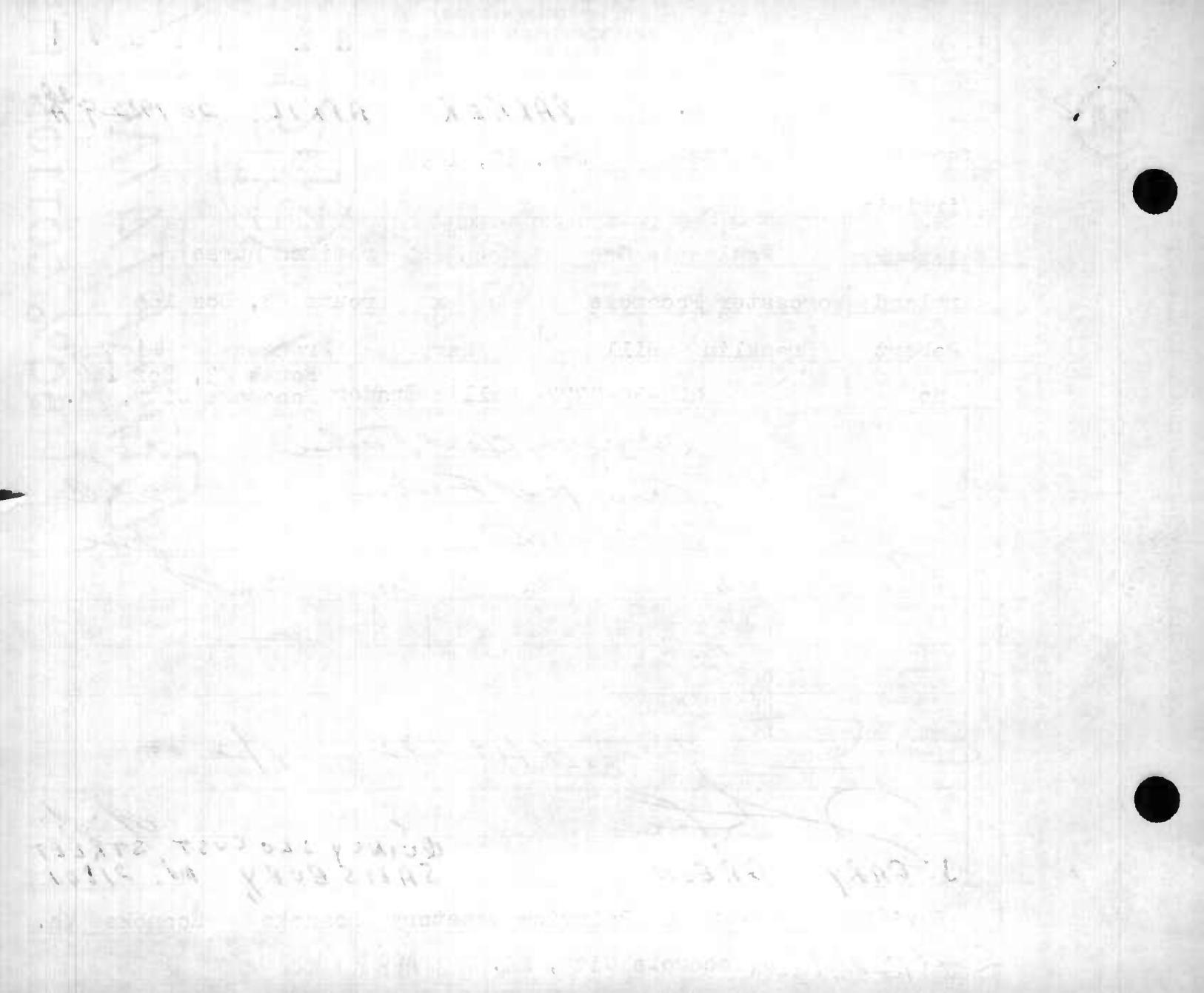
MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8211091

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MARY	MIDDLE H.	LAST PARKER	2a DATE OF DEATH APRIL 20 1982	MONTH 9 th	DAY	YEAR 82	2b HOUR 9 th			
3. SEX female			4. RACE white	5. DATE OF BIRTH Jan. 17, 1899			6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF OVER 14 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH wicomico				
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired nurse			12b. KIND OF BUSINESS OR INDUSTRY MD.				
13a. STATE Maryland			13c. CITY OR TOWN Worcester Pocomoke			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS route #3, Box 166				
14. FATHER'S NAME FIRST Robert			MIDDLE Franklin	LAST Hill	15. MOTHER'S MAIDEN NAME FIRST Mary			MIDDLE Frances	LAST Liptrap	ADDRESS Route #3, Box 166 Pocomoke City, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 228-30-7377A			17. INFORMANT Nellie Trader			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Heart Failure			DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Heart Failure			WEEK YES NO				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Coronary Disease													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NOT WORK			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (We) attended the deceased from <u>4/17/82</u> to <u>4/21/82</u> , that (I) (We) last saw the deceased alive on <u>4/21/82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (Did not) view the body after death.													
22d. PHYSICIAN'S NAME, TITLE OR RANK J. EARY GREEN			22e. ADDRESS QUINCY & LOCUST STREET SALISBURY MD. 21801			22f. DATE SIGNED 4/21/82							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/22/82			23c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery			23d. LOCATION CITY OR TOWN Roanoke				
24. FUNERAL DIRECTOR NAME Scott S. Mellen			25a. DATE REC'D. BY REGISTRAR APR 27 1982			25b. REGISTRAR'S SIGNATURE Anne J. [Signature]							
ADDRESS Pocomoke City, Md.													

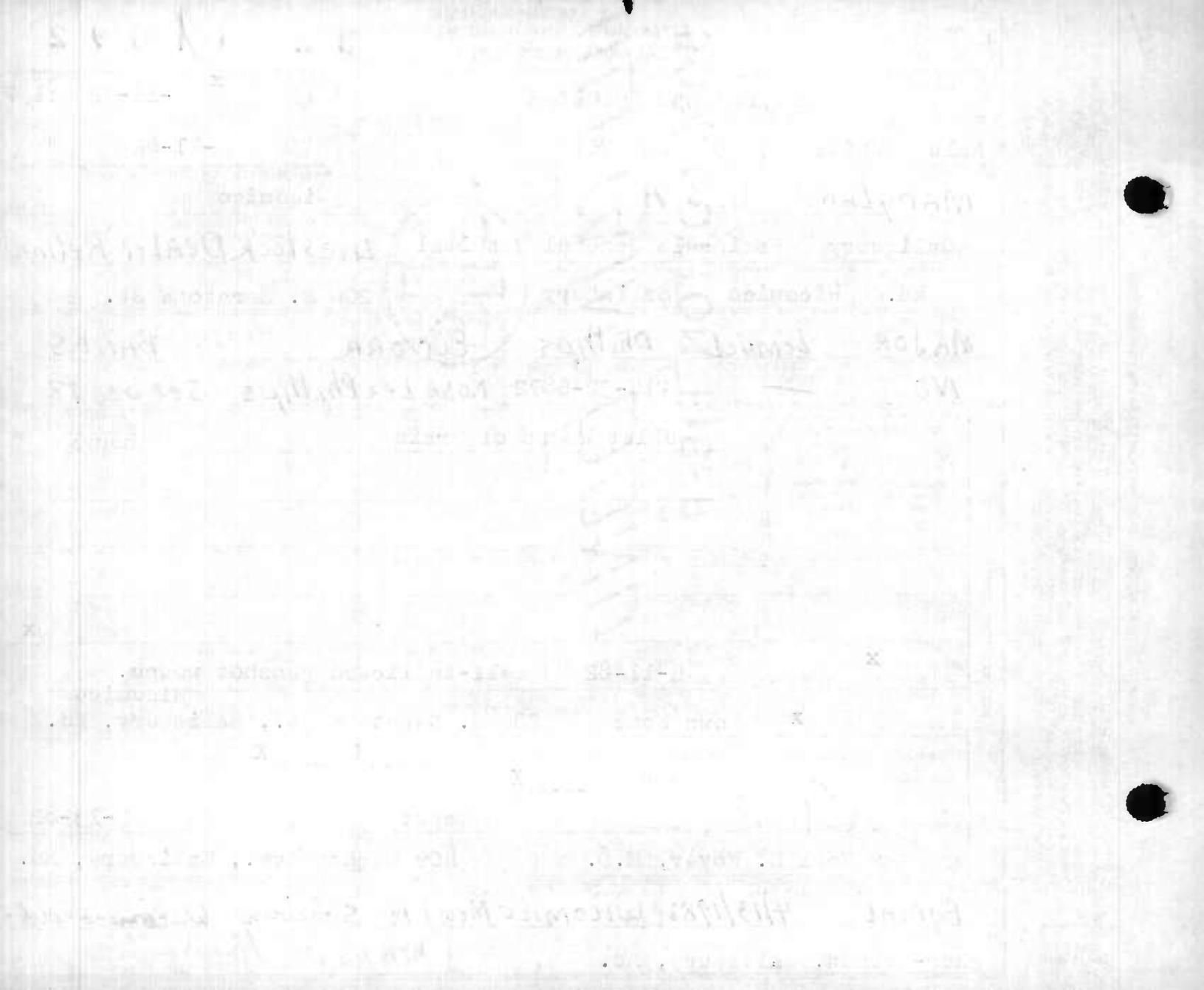


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11092
REG. NO.

1- STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)								2a. DATE KNOWN OF DEATH EST. MATED		2b. MONTH DAY YEAR		26 HOUR					
		FIRST		MIDDLE		LAST		<input checked="" type="checkbox"/> 4-11-82 19		4:15 P.M.									
		GRANVILLE LEE PHILLIPS																	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY YRS.		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. MONTH DAY YEAR		2d. HOUR			
Male		White		7 5 05		76		MONTHS		DAYS		4-11-82 19		11		M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?								8. MARRIED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		U. S. A.								WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		Wicomico					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE								12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital								LIVESTOCK Dealer Refined									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS											
Md.		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		206 S. Saratoga St.											
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME											
MAJOR		Lemuel		Phillips		EUDORA		BANKS											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.								17. INFORMANT		ADDRESS							
NO		214-32-6892								Rose Lee Phillips		See Sec 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1 DEATH WAS CAUSED BY: 9554		IMMEDIATE CAUSE (a) Bullet Wound of Brain								hours									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF																	
		(b)																	
		DUE TO, OR AS A CONSEQUENCE OF																	
		(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?									
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M., MONTH DAY YEAR P.M. 4-11-82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		Self-inflicted gunshot wound.													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) own home		21f. LOCATION STREET 206 S. Saratoga St., Salisbury, Md.		Wicomico COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion											
death resulted from: Natural causes <input type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input checked="" type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		M.D.		Deputy		MEDICAL EXAMINER													
EXAMINER'S NAME (TYPE OR PRINT)		409 Camden Ave., Salisbury, Md.								DATE SIGNED 4-13-82									
23a. BURIAL, CREMATION, REMOVAL (SPEC)		23b. DATE 4/13/1982		23c. NAME OF CEMETERY OR CREMATORIAL WICOMICO Mem PK		23d. LOCATION CITY OR TOWN Salisbury		COUNTY Wicomico STATE											
24. FUNERAL DIRECTOR NAME Baker-Bounds		ADDRESS Salisbury, Md.		25a. DATE REC'D. BY REGISTRAR APR 19 1982		25b. REGISTRAR'S SIGNATURE Diane J. Morris													
BP																			
DHMH-17 (VR A15 ME (5)) 15M 2/80																			



5

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUSELF. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1 STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 11093

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR A.M.
BESSIE P. POPE						4-5-82	19			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR P.M.
Female	White	3 24 1892	90			4-5-82	19			10A.M.
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.			NEVER MARRIED DIVORCED		Wicomico			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Cru-Mor Apt. 11, N. Division St.			Buyer Ret.		Dept Store			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		13f. ADDRESS		
Md.		Wicomico	Salisbury	YES <input type="checkbox"/>		N. Division St.		New York Ave.		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		Charles Shockley, Salisbury, Maryland			
		Elisha	Warner	Parsons	Martha		3409			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Emily Wimbrow				
No		218-20-4185		Charles Shockley						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years								
ASCVD										
4292										
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.		DUE TO, OR AS A CONSEQUENCE OF								
{										
(b)		DUE TO, OR AS A CONSEQUENCE OF								
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER								
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS								
Earl L. Royer, M.D.		409 Camden Ave., Salisbury, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		5/7/1982		Parsons Cemetery		Salisbury, Md.				
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Baker-Bounds, Salisbury, Md.				APR 12 1982		Anne J. [Signature]				

TO HOSPITAL OR ATTENDING PHYSICIAN: The [redacted] resuscitated by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **Page 4**
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as a burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

11094

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26 HOUR
Henry					Price Sr.	04	25	82	11 45 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		18. UNDER 24 HRS				
Male	Black	MONTH 09 DAY 06 YEAR 1906	75	MONTHS	DAYS	HOURS	MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH							
South Barnwell Carolina	U.S.A		Wisconsin							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Eden	(Home)	Walnut Tree Rd.								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE PREVIOUS ADDRESS)						13d. INSIDE CITY LIMITS?				
13a. STATE	13b. COUNTY	13c. CITY	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS					
Maryland	Wicomico	Eden	Walnut Tree Road Eden							
14. FATHER'S NAME	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Robert		Price	Lillie			Eden				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:							
no	250-16-6850	Spouse	Abdominal wall carcinoma							
IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) Epidemic carcinoma of rectum			6/27/80				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (c) Suprapubic cystostomy			May 1959				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I										
Impassable urethra 2" to stricture junction										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE		
22a. I certify that (1) (This hospital) attended the deceased from <u>March 31</u> 19 <u>82</u> , and that (2) (my) opinion death occurred on the date and hour and from the causes stated above. (1) (I) (did not) (did not) view the body after death.				62	April		19	82		
22b. SIGNATURE	DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22i. DATE SIGNED					
WALTER D. DE VAULT Jr.	MD				5/4/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS									
WALTER D. DE VAULT Jr., Medical Center Salisbury, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION CITY OR TOWN	COUNTRY		STATE				
Burial	5-1-82	Green Acres Mem. Pk.	Salisbury	Wicomico		Md.				
24. FUNERAL DIRECTOR NAME	833 West ADDRESS	25a. DATE RECD. BY REGISTRAR			REGISTRAR'S SIGNATURE					
Russell A. Fooks	main street Salisbury, Md.	MAY 5 1982			James J. Smith					

1991 2 TAX

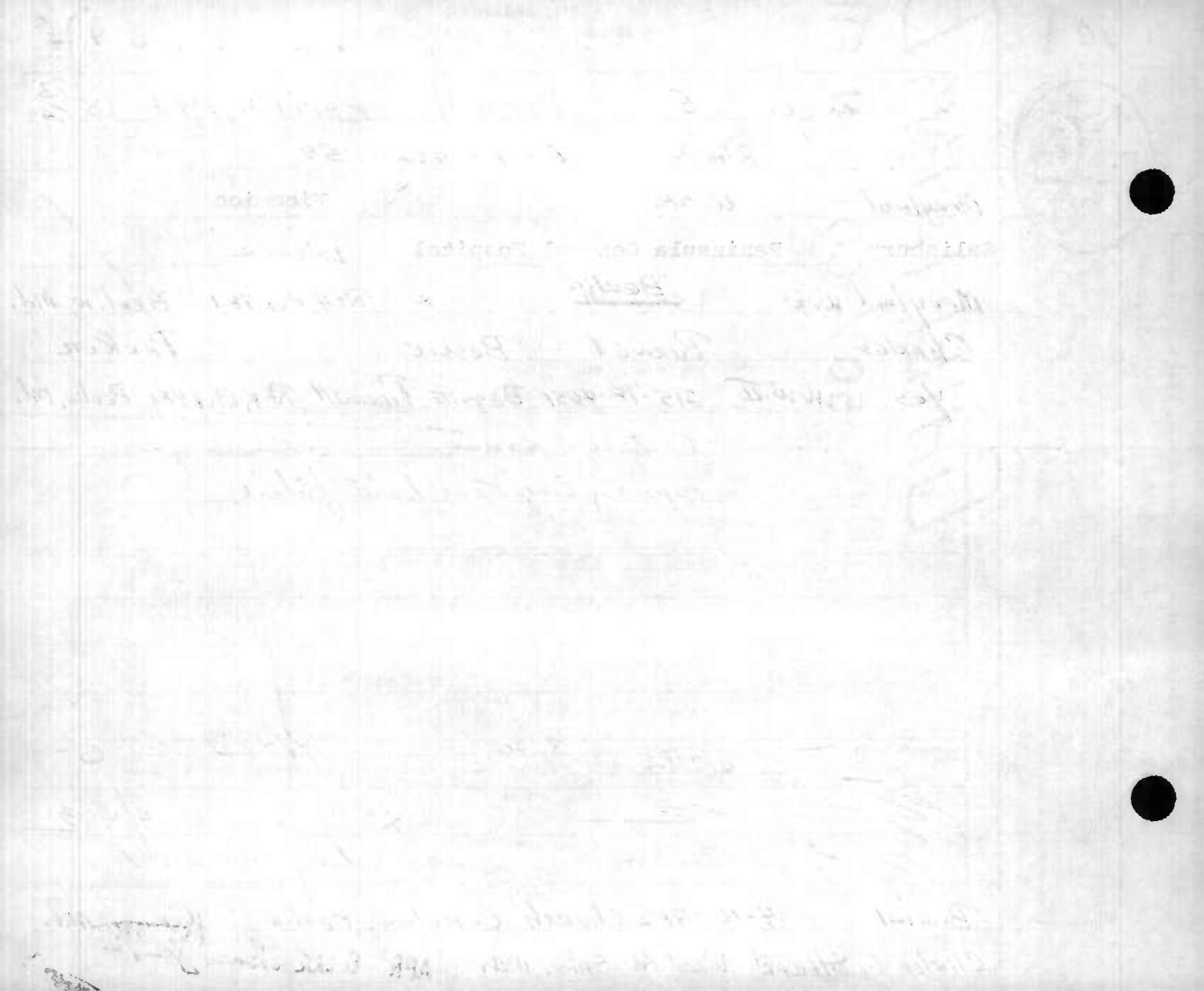
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 2 and 2 should be filled within 24 hours after death with the State Dept. of Health and Mental Hygiene (prior to burial), cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be consulted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 0 9 5		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
George E Purnell						April 4, 1982			5:03 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		Black		6 1 1922			59					
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			10. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
Maryland		U. S. A.										
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER			12b. KIND OF BUSINESS OR INDUSTRY MD.					
12b. JURISDICTION Maryland Wor.		13a. STATE Maryland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt 4 Box 481 Berlin, Md.					
14. FATHER'S NAME Charles		15. MOTHER'S MAIDEN NAME Bessie		16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW II 215-18-4051			17. INFORMANT Bessie Purnell Rt 4, Box 481 Berlin, Md.		
										18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF (b)		21. DUE TO, OR AS A CONSEQUENCE OF (c)								
4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		4280 Refractory congestive heart failure										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (this hospital) attended the deceased from 3/20, 19 to 4/4/82, 19, that (we) last saw the deceased alive on 4/3/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.												
22b. SIGNATURE George E. Purnell		22c. DEGREE		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 4/4/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George E. Purnell		22e. ADDRESS Box 49 Saline Mo 21061										
23a. BURIAL, CREMATION, REMOVAL (IF Y)		23b. DATE 4-10-1982		23c. NAME OF CEMETERY OR CREMATORIAL Church Cemetery			23d. LOCATION CITY OR TOWN Berlin			23e. COUNTY Wicomico		
24. FUNERAL DIRECTOR NAME Clinton F. Stewart West Rd Sals. Md.							25a. DATE REC'D. BY REGISTRAR APR 6 1982			25b. REGISTRAR'S SIGNATURE James J. Stewart		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 0 9 6	REG. NO.	
1 - STATE REGISTRAR												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Romey Sidney Pusey						April 27 1982			506			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			
Male			White			Oct. 5, 1908			73			
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			U.S.						Wicomico			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury			Peninsula General Hospital			Farmer						
13a. STATE Maryland			13b. COUNTY Somerset			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 4 Pine Knoll Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME Clara Hales									
Hilary												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS			
(If Yes, give war or dates)			220-01-9430			Mrs. Lelia A. Pusey, Princess Anne, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												
4249 <i>Obstructive Congestive failure</i> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO (b) AS A CONSEQUENCE OF <i>Arteriosclerotic & Varicita-</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Heart Disease</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 72 19 81 to 4/27 19 82, that (I) (we) last saw the deceased alive on 7/36 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <i>S. P. Raffetto</i>			22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>4/30-82</i>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. L. Raffetto</i>			22f. ADDRESS <i>C. G. H.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/29/82			23c. NAME OF CEMETERY OR CREMATORIAL Beechwood			23d. LOCATION CITY OR TOWN COUNTY STATE Princess Anne; Somerset, Md.			
24. FUNERAL DIRECTOR NAME <i>James L. Henman</i>			ADDRESS <i>Princess Anne</i>			25a. DATE REC'D. BY REGISTRAR MAY 10 1982			25b. REGISTRAR'S SIGNATURE <i>James J. Johnson</i>			

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Book Review

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be informed of it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	1	0	9	7
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
Ebe			C.	Quillen		4-17-82						2:49 P M						
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
Male			White	Oct. 28 1908			73			MONTHS	YEARS	HOURS	MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Delaware			USA						Wicomico MD									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Salisbury			Peninsula General Hospital			Accountant			Block Co.									
13a. STATE 13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS									
Delaware			Sussex			Selbyville			Fenwick Road									
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)								
Clinton				Quillen	Manie					16b. SOCIAL SECURITY NO. 16c. INFORMANT 160-01-0111 Dorothy Quillen Selbyville, DE								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												Due to, or as a consequence of (b) <i>Arteriosclerotic Cardiovascular disease</i>						
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY			STATE				
22a. I certify that (1) (this hospital) attended the deceased from 4/16/82 to 4/17/82, the (1) (we) last saw the deceased alive on 4/16/82, 1982, and that in my (our) opinion death occurred on the date and hour from the causes stated above. (1) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 4/17/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chrysler L. Raab M.D.												22e. ADDRESS Box 49 Salisbury MD 21801						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 4-20-1982			23c. NAME OF CEMETERY OR CREMATORIAL Mariner's Bethel			23d. LOCATION CITY OR TOWN Ocean View		COUNTY Sussex			STATE DE				
24. FUNERAL DIRECTOR NAME Clark W. Hastings, Selbyville, Del.			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 20 1982			25b. REGISTRAR'S SIGNATURE James J. Martin									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8211098						
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR									
JANINA Monica Rankin						April 5, 1982			8:55 AM									
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.								
Female		WHITE		4-5-82			1 YRS			144								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO			10. CITY OR TOWN OF DEATH Salisbury								
MD.		USA																
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)																
Peninsula General Hospital		N/A																
13a. STATE MD.		13b. COUNTY DOOR		13c. CITY OR TOWN BERKIN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 781 OCEAN PLACES								
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME JO ANN HAY																
MICHAEL T. RANKIN																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT M.T. RANKIN, BERKIN, MD.			ADDRESS			18. CAUSE OF DEATH Enter only one cause per line for 1a, (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		—											Cardiac Arrest			—		
7621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure										1hr 25min						
		DUE TO, OR AS A CONSEQUENCE OF (c) Severe Prematurity										1hr 44min						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from 415, 19 82, to 415, 19 82, that (I) (we) last saw the deceased alive on 415, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE Karin Cleary		22c. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/15/82													
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS																
23a. BURIAL, CREMATION, REMOVAL (SPECIAL)		23b. DATE 4-9-82		23c. NAME OF CEMETERY OR CREMATORIAL SUNSET M.P.			23d. LOCATION BERKIN, DOOR, MD.											
BURIAL																		
24. FUNERAL DIRECTOR NAME ULRICH Funeral Home		ADDRESS BERKIN, MD.			25a. DATE REC'D. BY REGISTRAR APR 12 1982			25b. REGISTRAR'S SIGNATURE Anne Justine										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 8 2 1 1 0 9 9												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			2b HOUR P			
Grace HART REED						April 22 1982			7:10 M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		
FEMALE		White		5 28-16			65			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.		
YA.		U.S.A.										
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper			12b. KIND OF BUSINESS OR INDUSTRY		
YA.		ACCOMACK		ATLANTIC			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS COOPER PARSONSBURG, MD.		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
EBBIE		CARRIE										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS								
NO		227-34-3366		JAMES E. HART			PARSONSBURG, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2500												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebrovascular accident</u> (c) <u>Diabetes mellitus</u>												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Urinary tract infection												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) lost sow the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE M. Shrestha		DEGREE		22c. DATE SIGNED 9-22-82								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Shrestha, M.D.		22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-25-82		23c. NAME OF CEMETERY OR CREMATORIAL FAIRVIEW 100W			23d. LOCATION CITY OR TOWN ONANCOCK COUNTY ACCOMACK STATE VA.					
24. FUNERAL DIRECTOR NAME TOM WILLIAMS - ONANCOCK, VA. 23417		25a. DATE FOR BURIAL BY REGISTRAR APR 28 1982		25b. REGISTRAR'S SIGNATURE Name of								
BP _____												
DHMH - 16 50M 1/81 (VRA 15. 4)												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	1	1	0
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Hilda Taylor Revell						April 8 1982						7:00 P.M.					
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)					
Female			White			21-17-1897						82 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH					
Virginia			U.S.A.						Wicomico			Salisbury					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Peninsula General Hospital												Housewife			None		
13a. STATE AND COUNTY												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Va Prince George's												Yes			Atlantic		
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME											
Ezra W. Taylor						Mary						Gladding					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO			222-40-8233			Barbara Browning			Canton, NC			10 min					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY:												19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 10					
IMMEDIATE CAUSE (a) Asystole												Cholelithiasis - Gallbladder					
5742 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last.												DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction					
DUE TO, OR AS A CONSEQUENCE OF (c)												16 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 10																	
20a. DATE OF OPERATION 3-15-82			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholelithiasis - Large Gallbladder			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 3-7-1982 to 4/8/1982, that (I) (we) lost saw the deceased alive on 4/8/1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE George Galifianakis					
22c. DEGREE M.D.												22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22e. ADDRESS George Galifianakis			22f. ADDRESS Medical Center			22g. ADDRESS Salisbury, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4-11-1982			23c. NAME OF CEMETERY OR CREMATORY Taylor's Memorial			23d. LOCATION CITY OR TOWN Temporaneously Accomack Co. Va			23e. COUNTY STATE					
Burial																	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 13 1982			25b. REGISTRAR'S SIGNATURE Helen Jones Martin								

2011-2012
Population Census Household

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8211101												
												REG. NO.												
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR			
			Nellie Bly									Rew			April 28					1982	8 10 P M			
3 SEX			4 RACE			5 DATE OF BIRTH MONTH DAY YEAR									6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female			White			Feb. 19, 1890									92			MONTHS	YEARS		MONTHS	DAY	HOURS	MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9 BALTIMORE CITY OR COUNTY OF DEATH												
Maryland			USA									Wicomico												
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY															
Salisbury			Peninsula General Hospital			Housewife																		
13a STATE			13b COUNTY			13c CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS												
Maryland			Wicomico			Pocomoke						Snow Hill Lane												
14 FATHER'S NAME FIRST			MIDDLE			LAST			15 MOTHER'S MAIDEN NAME FIRST			MIDDLE			16 LAST									
George						Brittingham			Nettie						Carmine									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS															
NO			224-28-6423			John B. Parsons Home, Lemon Hill, Salisbury																		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
IMMEDIATE CAUSE (a) <i>Heart block</i>												minutes												
4100 DUE TO, OR AS A CONSEQUENCE OF (b) <i>not likely myocardial infarction</i>												hours												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																								
DUE TO, OR AS A CONSEQUENCE OF (c) <i>coronary artery disease</i>																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Pulmonary Emboli, congestive heart failure, COPD.</i>																								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY			STATE									
22a I certify that (I) (the hospital) attended the deceased from <i>9/15/82</i> to <i>10/28/82</i> , that (I) (we) lost saw the deceased alive on <i>10/28/82</i> , and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did <input type="checkbox"/> did not <input type="checkbox"/> view the body after death.																								
22b SIGNATURE <i>Allegro</i>			22c DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/30/82															
22e PHYSICIAN'S NAME (TYPE OR PRINT) Deepak Saggar, M.D.			22f ADDRESS Salisbury, Maryland																					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 5/3/82			23c NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery			23d LOCATION CITY OR TOWN Salisbury, Wicomico, Maryland			COUNTY			STATE									
24 FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Maryland			ADDRESS			25a DATE REC'D. BY REGISTRAR MAY 4 1982			25b. REGISTRAR'S SIGNATURE <i>Frances Jean Arthur</i>															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. File & may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	1	1	0	2					
												REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR pm					
Fred			NMN			Ricketts						April 8, 1982						12:15 M					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS								
male			black			MONTH DAY YEAR Nov. 10, 1910			71			MONTHS DAYS			HOURS MIN.								
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Millington, Md.			U.S.A.						Wicomico			Salisbury			Deer's Head Center, Salisbury			Factory					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS											
Md.			Kent			Millington																	
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
Clarence						Ricketts			Stella			55-05-2724			Margaret Dickerson			21651			Coleman		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a) <u>cerebrovascular accident</u>												1477.1881.30 min											
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												4/8/1982											
DUE TO, OR AS A CONSEQUENCE OF (b)																							
DUE TO, OR AS A CONSEQUENCE OF (c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (the hospital) attended the deceased from <u>12/15</u> 19 <u>81</u> to <u>4/8</u> 19 <u>82</u> , that (I) (we) lost sow the deceased olive on <u>4/8</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.)																							
22b. SIGNATURE <i>Inja J. Hwang</i>			DEGREE									ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input checked="" type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Inja J. Hwang, M.D.			22e. ADDRESS Deer's Head Center, Salisbury, MD 21801									22c. DATE SIGNED <u>4/8/82</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/13/82			23c. NAME OF CEMETERY OR CREMATORIAL John Wesley Cem.			23d. LOCATION CITY OR TOWN Millington, Kent Md.			23e. COUNTY			STATE								
24. FUNERAL DIRECTOR NAME Gary B. Fellows, Millington, Md. 21651			25a. DATE REC'D. BY REGISTRAR APR 20 1982									25b. REGISTRAR'S SIGNATURE <i>James Jan Wether</i>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

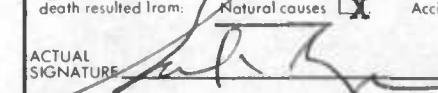
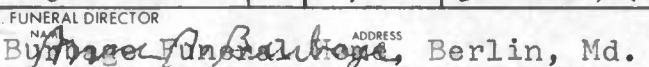
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

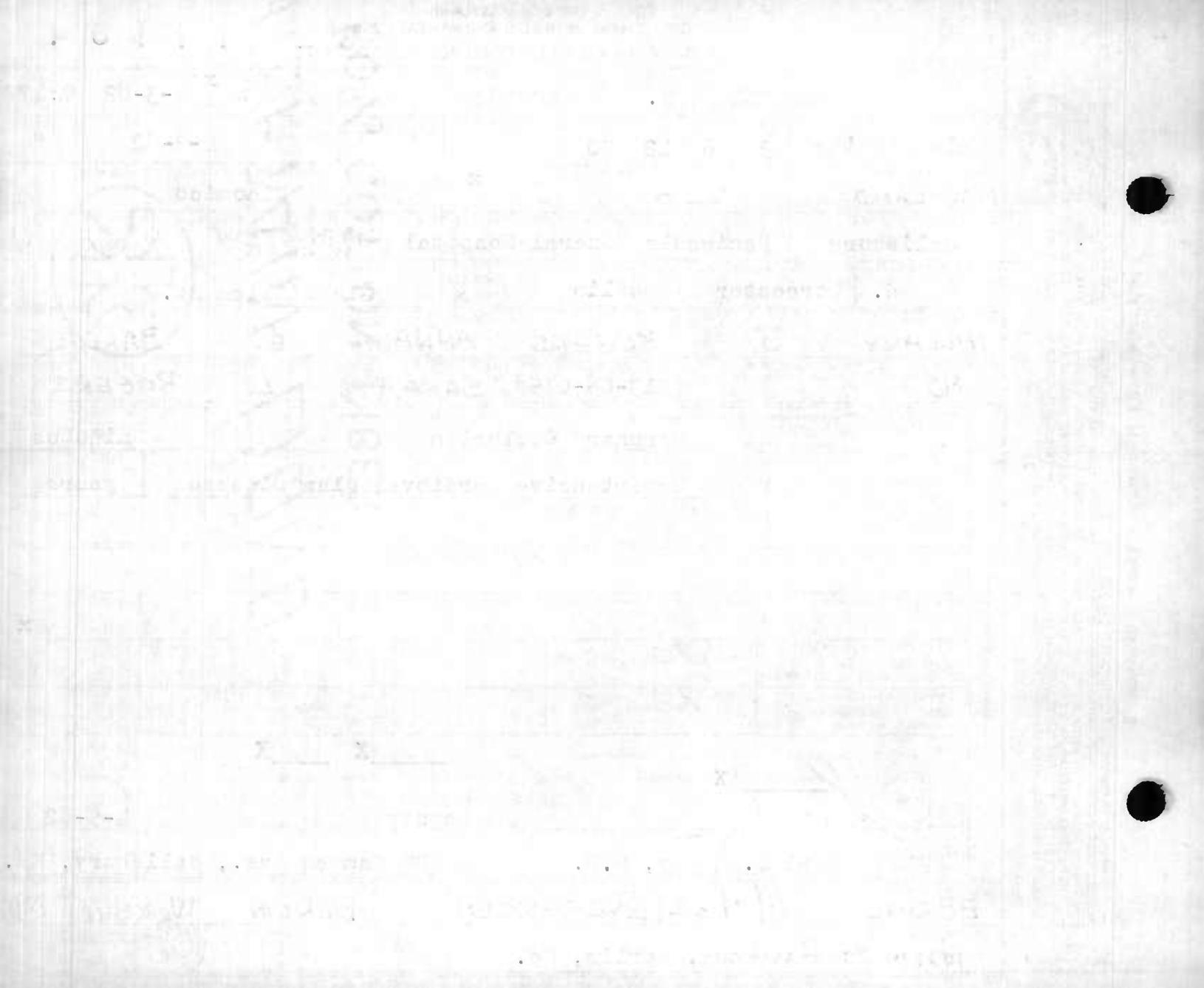
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner may be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 1 1 1 0 3	REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME FIRST <u>ALVIN</u> MIDDLE <u>J.</u> LAST <u>Rogers</u>						2a. DATE OF DEATH MONTH <u>APRIL</u> DAY <u>10</u> YEAR <u>1982</u>			2b. HOUR <u>6:35 P.M.</u>		
3. SEX <u>MALE</u>			4. RACE <u>WHITE</u>			5. DATE OF BIRTH MONTH <u>JAN.</u> DAY <u>14</u> YEAR <u>1926</u>			6. AGE (IN YEARS LAST BIRTHDAY) <u>56</u> YRS.			IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN. <u>0</u>		
7a. BIRTHPLACE COUNTRY <u>DELAWARE</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Wicomico</u>			10. CITY OR TOWN OF DEATH <u>Salisbury</u>		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Peninsula General Hospital</u>												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>CARPENTER & ELECTRICIAN</u>		
13a. STATE COUNTY <u>DELAWARE</u> <u>SUSSEX</u>			13b. CITY OR TOWN <u>FRANKFORD</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <u>R.D. 3, BOX 48</u>					
14. FATHER'S NAME FIRST <u>CHARLES</u> MIDDLE <u>ROGERS</u> LAST			15. MOTHER'S MAIDEN NAME MIDDLE <u>ROGERS</u> LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <u>222-12-0922</u>			17. INFORMANT <u>OLIVE V. ROGERS - FRANKFORD, DE.</u>			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Small cell carcinoma of lung w/ widespread metastasis</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost</u>														
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <u>417</u> CITY OR TOWN <u>Salisbury</u> COUNTY <u>Sussex</u> STATE <u>MD</u>								
22a. I certify that (I) <u>the physician</u> attended the deceased from <u>4/10/82</u> to <u>4/10/82</u> , and that in (my) <u>the</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> <u>not</u> view the body after death.														
22b. SIGNATURE <u>Joseph W. Grasso</u>			22c. DEGREE <u>MD</u>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>4/10/82</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph W. Grasso</u>			22e. ADDRESS <u>1300 S. Division St. - Salisbury Md</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>4-14-82</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>PRINCE GEORGE'S CEM</u>			23d. LOCATION CITY OR TOWN <u>DAGSBORO, SUSSEX, DEL.</u> COUNTY <u></u> STATE <u></u>			24. FUNERAL DIRECTOR <u>John Molar</u>		
25a. DATE REC'D. BY REGISTRAR <u>APR 16 1982</u>			25b. REGISTRAR'S SIGNATURE <u>John J. Molar</u>											
ADDRESS <u>FRANKFORD, DELAWARE</u>														

1966 T1 1000 1000 1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1a. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM-3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 11104		
1- STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH 4 MONTH 4 DAY 19 YEAR 82									2b. HOUR 9:47P M		
1. DECEASED NAME (TYPE OR PRINT)			FIRST RUSSELL			MIDDLE H.			LAST ROGERS			2c. DATE PRONOUNCED DEAD 4-3-82 19 M		
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH 3 DAY 6 YEAR 12		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 70		7. IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0		8. IF UNDER 24 HRS. MONTHS 0 DAYS 0 HOURS 0 MIN 0		
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico					
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK) CONSTRUCTION WORKER			12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		
13a. STATE Md. COUNTY Worcester			13c. CITY OR TOWN Berlin			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 614 William St.					
14. FATHER'S NAME FIRST HILLARY			MIDDLE J.			LAST ROGERS			15. MOTHER'S MAIDEN NAME FIRST ANNA			MIDDLE E. LAST BAKER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN)			16b. SOCIAL SECURITY NO. 213-05-0758			17. INFORMANT SARAH			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100			Coronary Occlusion			DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Disease			years					
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER								
23a. EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D.			23b. DATE 4/7/82			23c. NAME OF CEMETERY OR CREMATORY EVERGREEN			23d. LOCATION TOWNSHIP BERLIN			DATE SIGNED 4-5-82		
24. FUNERAL DIRECTOR NAME 			ADDRESS Berlin, Md.			25a. DATE REC'D. BY REGISTRAR APR 12 1982			25b. REGISTRATION NUMBER 					
BP _____														
DHMH-17 (VR A15 ME (5))														
15M 2/80														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, or by the physician retained by the hospital or attending physician.

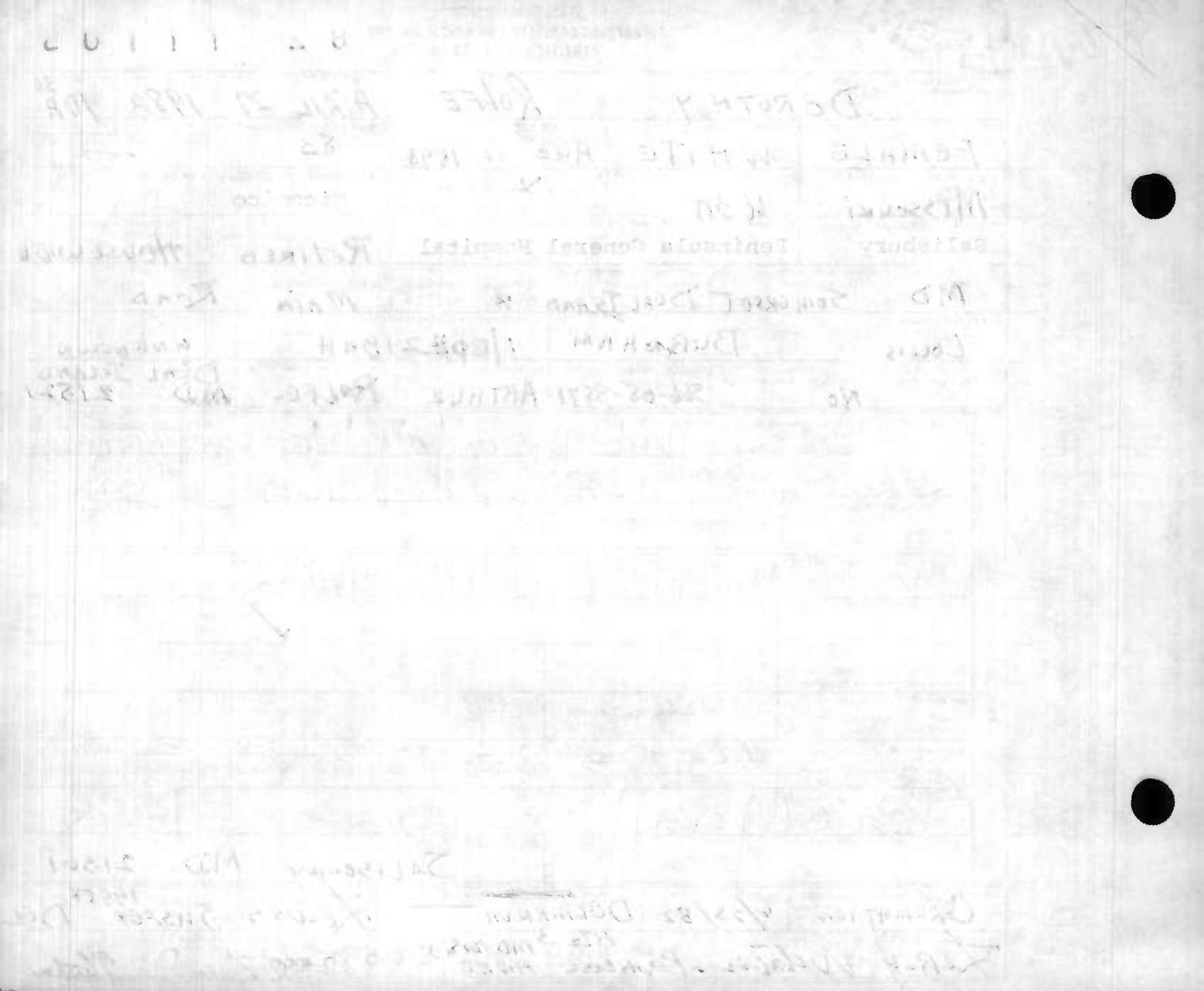


Print 4 in 1

15

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8211105
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
DOROTHY					ROLFE	APRIL	27	1982	30	10 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		AUG 12 1898		83		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		YRS.			
Missouri		USA				Wicomico					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		Peninsula General Hospital		RETIRED		HOUSEWIFE					
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS					
MD		Somerset		Deal Island		MAIN		Road			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Louis				Burrougham		Hepzibah				Uniconow	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			566-05-8571			ARTHUR ROLFE			Deal Island MD. 21821		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						45 minutes					
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						Acute Myocardial Infarction					
DUE TO, OR AS A CONSEQUENCE OF (b)						Coronary artery disease					
DUE TO, OR AS A CONSEQUENCE OF (c)						Years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from 4-27-1982 to 4-27-1982, that <input type="checkbox"/> (we) last saw the deceased alive on 4-27-1982 and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.			22b. LOCATION CITY OR TOWN			CITY OR TOWN			COUNTY STATE		
22c. SIGNATURE			22d. DEGREE			22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED		
Dorothy M. Roll									4-27-82		
22g. PHYSICIAN'S NAME (TYPE OR PRINT)			22h. ADDRESS			22i. NAME OF CEMETERY OR CREMATORIAL			22j. LOCATION CITY OR TOWN		
CREMATION			4/28/82			DELMARVA			DELWES SUSSEX DEL		
23a. BURIAL, CREMATION, REMOVAL 1500			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		
CREMATION			4/28/82			DELMARVA			DELWES SUSSEX DEL		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
LEROY Webster - PRINCESS ANNE			RT 3 MD. 21823			APR 29 1982			Dorothy M. Roll		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transtom permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be contacted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 1 1 0 6						
										REG. NO.						
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH							MONTH	DAY	YEAR	2b. HOUR			
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST		April 7, 1982			47 M			
Winfred L. Sherkey																
3 SEX			4 RACE			5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF OLDER THAN 12 HRS HOURS MIN.		
Male			White			MONTH DAY YEAR		82			YRS			47		
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH				
Maryland			USA						Wicomico			Salisbury				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Peninsula General Hospital										Labor			Lumber Co.			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Maryland Worcester Snow Hill													103 Belt Street			
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME										
William M. Sherkey						Lillie Mae Layfield										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			220-33-0307			Richard L. Sherkey, Snow Hill, Md.										
									wrongful heart failure							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b)			DUE TO, OR AS A CONSEQUENCE OF										
			(c)			DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
			P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3128 1982 to 471982, that (I) (we) last saw the deceased alive on 4/6/82 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													22c. DATE SIGNED			
22b. SIGNATURE W. Ben Horner MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
															4/7/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 4-9-82			23c. NAME OF CEMETERY OR CREMATORIUM McKemie Presbyterian			23d. LOCATION CITY OR TOWN Snow Hill, Maryland			COUNTY			STATE	
24. FUNERAL DIRECTOR NAME Norman E. Dennis, Snow Hill, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 12 1982			25b. REGISTRAR'S SIGNATURE Norman E. Dennis							

introducing elements

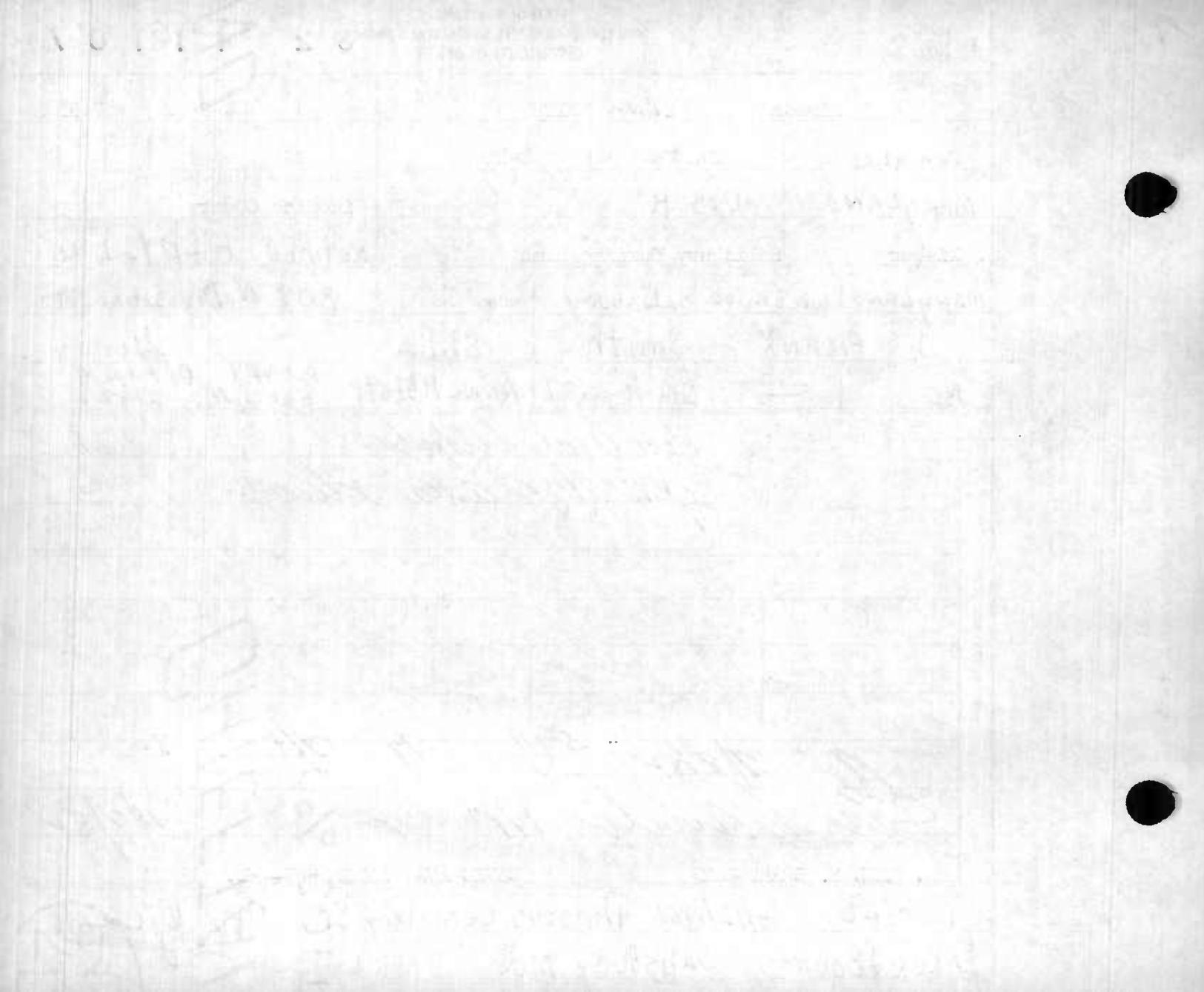
variables

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (Items 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

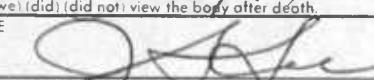
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	1	1	0	7					
												REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR								
Minnie			Edna		SMITH					4-9-82					7:35 A M								
1. SEX Female			4. RACE White		5. DATE OF BIRTH MONTH 1		DAY 21			YEAR 1986		6. AGE (IN YEARS LAST BIRTHDAY) 96		IF UNDER 1 YEAR YRS.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.							
7a. BIRTHPLACE COUNTRY MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County		10a. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired C P P Tel Co.		12b. KIND OF BUSINESS OR INDUSTRY MD.					
13a. STATE MARYLAND			13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 807 N. Division St.		14. FATHER'S NAME J. FRANK		15. MOTHER'S MAIDEN NAME ELBA		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 312-10-0227		17. INFORMANT Anne Abbott		18. ADDRESS Box 416 EDEN, MD. 21822	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4340			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7th.		18. DUE TO, OR AS A CONSEQUENCE OF (b) General Fluorosis		18. DUE TO, OR AS A CONSEQUENCE OF (c) Generalized dental caries		19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 5th		21f. LOCATION STREET CITY OR TOWN STATE 19 80		22a. I certify that (I/We) hospital attended the deceased from saw the deceased alive on 19 above, (I/We) (did) (did not) view the body after death.		22b. SIGNATURE DR. EARL M. BEARDSLEY		22c. DEGREE MD		22d. DATE SIGNED 4/9/82				
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			23b. DATE 4/12/1982		23c. NAME OF CEMETERY OR CREMATORIAL PARSONS Cemetery		23d. LOCATION CITY OR TOWN Salisbury		23e. COUNTY Wicomico		24. FUNERAL DIRECTOR NAME BAKER & BOUNDS		25a. DATE REC'D. BY REGISTRAR APR 14 1982		25b. REGISTRAR SIGNATURE Anne Abbott								
BP			ADDRESS Salisbury, MD.																				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical certifier, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	1	0	8
												REG. NO.					
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 10 40 A M					
William Martin			Smith			APRIL 19, 1982											
2. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico			MD.					
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farming								
13a. STATE Maryland			13b. COUNTY Wicomico			13c. CITY OR TOWN Salisbury			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Box 298, Rt. 8					
14. FATHER'S NAME FIRST Isaac			MIDDLE Bethards			LAST Smith			15. MOTHER'S MAIDEN NAME FIRST Hannah			MIDDLE Elizabeth			LAST Murphy		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-36-1484A			17. INFORMANT Mrs. Blanche W. Smith (wife)			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH and								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Alzheimer's disease																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I) (the hospital) attended the deceased from <u>4/19/82</u> to <u>4/19/82</u> , that (I) (we) last saw the deceased alive on <u>4/19/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE 			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/19/82								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. G. GREEN MD			22e. ADDRESS QUINCY & LOCUST ST, SALISBURY, MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/22/82			23c. NAME OF CEMETERY OR CREMATORIAL Parsons Cemetery			23d. LOCATION CITY OR TOWN Salisbury, Wicomico, Md.			23e. COUNTY Wicomico			23f. STATE Md.		
24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Md.			25a. ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Md.			25b. DATE REC'D. BY REGISTRAR APR 27 1982			25c. REGISTRAR'S SIGNATURE 								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/cremation permit. Then please remove carbon copies, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removed.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND

**DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

8 2 1 1 1 0 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			1. FIRST	1. MIDDLE	1. LAST	2. DATE OF DEATH	2. MONTH	2. DAY	2. YEAR	2b. HOUR		
JAMES Elwood SPARROW						4	7	82	640 p.m.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
MALE		CAUC		MONTH	DAY	YEAR	67	YRS	MONTHS	DAYS	IF UNDER 24 HRS	
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Virginia		U.S.A.						Wicomico				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury		Peninsula General Hospital			Parts Mgr.			Pilchard Bros				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Va		Accomack		New Church				Kate Taylor				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		ADDRESS				
W. E. Sparrow						Kate						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		203-01-4824			Mgntle Sparrow - New Church, Va		Cause of death: Acute Myocardial Arrest		HRS			
4100		DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure							HRS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c) Acute Myocardial Arrest							HRS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/6, 1982, to 4/1, 1982, that (we) last saw the deceased alive on 4/7, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												
22b. SIGNATURE		22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED					
Donald M. WOOD		MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		4/7/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
D. M. WOOD		P64										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE	
Burial		4-10-1982		Downing Cemetery			Oak Hall		Accomack Co.		Va.	
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE RECEIVED BY DIRECTOR		25b. DIRECTOR'S SIGNATURE					
Mark		Temperanceville, Va										

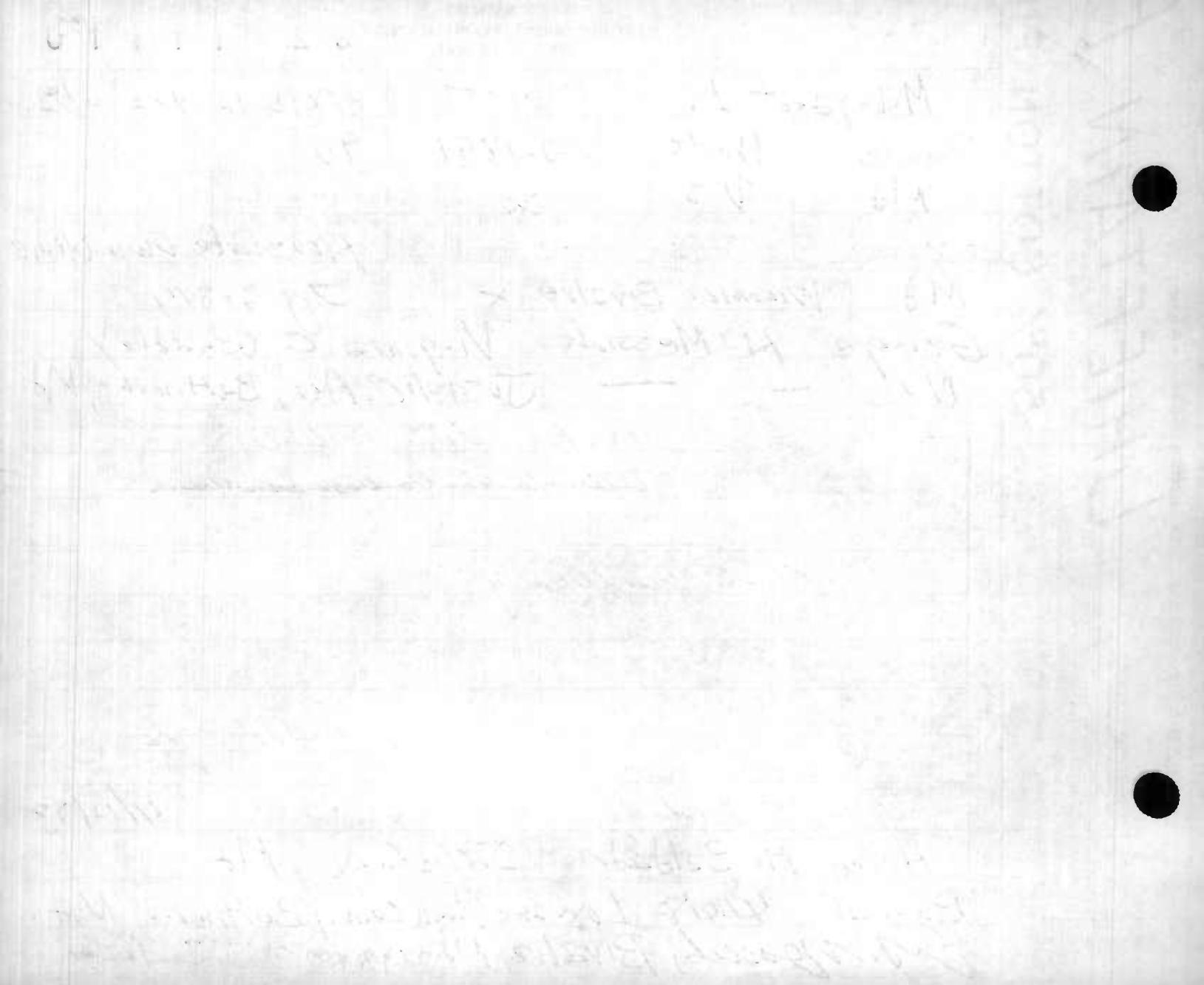
Indonesia, Flores, Flores

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8211110														
											REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR											
Margaret L.						SWIFT			APRIL 12, 1982						4 16 44 AM											
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH										
Female		White		7-2-1891			90			MD			U.S.			Wicomico										
MARRIED <input type="checkbox"/>		NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Salisbury		Peninsula General Hospital			Housewife			13a. STATE MD			13b. COUNTY Wicomico			13c. CITY OR TOWN Bivalve			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 29 21814						
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
George			H.			Messick			Virginia			C. Bradley			No			—			Joseph C. Aco, Baltimore, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												congestive heart failure														
4292												DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Cardiovascular Disease</i>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												Final emphysemy														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I) attended the deceased from saw the deceased alive on 4/12/82, to 4/12/82, 19 02, to 4/12/82, 19 02, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE Helen M. Baldado			DEGREE M.D.			22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 4/14/82														
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			Helen M. Baldado			22e. ADDRESS 52156ex, Md.			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4/14/82			23c. NAME OF CEMETERY OR CREMATORIUM Lorraine Crem. & Burial, Baltimore, Md.			23d. LOCATION CITY OR TOWN			COUNTY					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 13 1982			25b. REGISTRAR'S SIGNATURE James J. Miller																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use on the burial permit. Then please remove carbon papers. Pages 3 & 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	1	1	1	1	1		
										REG. NO.								
1. DECEASED NAME (TYPE OF PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Roman			William				Thornes		April			9	1982	9:10 AM				
3. SEX <i>Male</i>			4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>July 7, 1922</i>		6. AGE (IN YEARS LAST BIRTHDAY) 59			7. IF UNDER 1 YEAR MONTHS		8. IF UNDER 24 HRS DAYS		9. HOURS		10. MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Jenkinsbridge, Va.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i>			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>DIESEL MECHANIC</i>			11. KIND OF BUSINESS OR INDUSTRY				
10. CITY OR TOWN OF DEATH <i>Salisbury</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i>		12a. STREET ADDRESS <i>1030 Pierce Ave.</i>			12b. ADDRESS			13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13b. STREET ADDRESS				
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Salisbury</i>		13d. ADDRESS			14. FATHER'S NAME FIRST <i>James</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Sally</i>		16. ADDRESS MIDDLE <i>Ann</i>		LAST <i>Bull</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>			16b. SOCIAL SECURITY NO. <i>WW II</i>		17. INFORMANT ADDRESS <i>Mrs. Jackie S. Thornes (wife)</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>lung Cancer with widespread metastasis</i>			19. APPROXIMATE INTERVAL BETWEEN SUNSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DOUE TO, OR AS A CONSEQUENCE OF (b) { DOUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (This hospital) attended the deceased from <i>4/18</i> to <i>4/19</i> , 1982, that (I) (we) last saw the deceased alive on <i>4/18</i> 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>Joseph A. Grasso</i>			22c. DEGREE <i>(M)</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>4/19/82</i>									
22e. PHYSICIAN'S NAME (TYPE OF PRINT) <i>Joseph A. Grasso</i>			22f. ADDRESS <i>1100 S. Division St</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>4/13/82</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Wicomico Memorial Park</i>			23d. LOCATION CITY OR TOWN <i>Salisbury, Wicomico, Maryland</i>			23e. COUNTY STATE						
24. FUNERAL DIRECTOR NAME <i>HOLLOWAY FUNERAL HOME</i>			ADDRESS <i>Salisbury, Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>APR 14 1982</i>			25b. REGISTRAR'S SIGNATURE <i>Frances Jean Hartman</i>									

University of Western Ontario

Graduate School

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon signature. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

Item 4 per phone 5/6/82 dad

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 1 1 1 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
SARAH J. TILGMAN						APRIL 26, 1982				6 A. M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		
FEMALE		Black F		MONTH	DAY	YEAR	65	YRS.	MONTHS	DAYS	HOURS	MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.						
MD.		U.S.		Wicomico								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury			Peninsula General Hospital			LABORER						
13a. STATE 13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Md			Som Upper Hill			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Box 276 Upper Hill Md.			
14. FATHER'S NAME FIRST			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST			
SAMUEL P.			Johnson			Sarah			Torpin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			219-03-5811			Yvonne Coleman - Upper Hill Md.						
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>mitral regurgitation/congestive heart failure</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) <u>mitral valveopathy</u> (c)												
DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>C. Stegman</u>		DEGREE <u>MD</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED PRINCESS ANN 21853			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS P.O. Box 40										
C. STEGMAN		PRINCESS ANN 21853										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION CITY OR TOWN Upper Hill Md		23e. COUNTY Som Md				
Burial		5/1/82		Upper Hill								
24. FUNERAL DIRECTOR <u>Hatley E. and Crispel M.D.</u>		25a. DATE REC'D. BY REGISTRAR MAY 3 1982					25b. REGISTRAR'S SIGNATURE <u>June Jan Smith</u>					

25. April 1921 8 yrs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	1	1	1	3
												REG. NO.						
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR									
1. DECEASED NAME (TYPE OR PRINT)			LAST			April 22 1982			9 ²⁰ PM									
William James Washington Tingle																		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)									
Male			White			MONTH DAY YEAR			72									
						June 19, 1909			YRS									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland			USA						Wicomico									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Salisbury			Peninsula General Hospital			Mechanic			Auto									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Maryland			Wicomico			Parsonsburg			YES <input type="checkbox"/> NO <input type="checkbox"/>			Rt. 2, Old Ocean City Rd.						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST			FIRST MIDDLE LAST															
George Washington Tingle			Bessie Ethel Quillen															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
No			214-10-6194			Mrs. Helen A. Tingle (wife) same as 13												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:																		
IMMEDIATE CAUSE (a) <u>Cancerous</u>																		
1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.																		
(b) <u>gratally</u> <u>glucosuria</u>																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
19						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			22f.									
						Salisbury, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN									
Burial			4/25/82			Wicomico Memorial			COUNTY STATE									
24. FUNERAL DIRECTOR			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
						APR 27 1982			James Jan Harten									
NAME HOLLOWAY FUNERAL HOME, Salisbury, Md.																		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2	1 1 1 1 4	
												REG. NO.		
1 - FOR STATE REGISTRAR			2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR					
1. DECEASED NAME (TYPE OR PRINT)			1. FIRST MIDDLE			1. DATE OF BIRTH			2. DATE OF DEATH					
BEATRICE FRANCES			TRADER			MONTH 11 DAY 15 YEAR 11			APRIL 21 1982 8 A.M.					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)					
FEMALE			NEGRO			MONTH 11 DAY 15 YEAR 11			70 YRS.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Allen, Maryland			U.S.A.						Wicomico					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
Salisbury			Peninsula General Hospital			retired laborer			domestic					
13a STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
MARYLAND			WICOMICO			EDEN						RT. #1, BOX 372		
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
BERNIE			JONES			BETTY						TULL		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			-----			BEATRICE EVANS			SAME AS ABOVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Aspiration during sleep.</u>														
5580 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastritis</u> (c) <u></u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Dehydration</u> <u>Anemia</u> <u>Diabetes mellitus</u>														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>4-18-1982</u> to <u>4-21-1982</u> that (2) (we last saw the deceased alive on <u>4-20-1982</u>) and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) <input type="checkbox"/> view the body after death.														
22b. SIGNATURE <u>Slaggan</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/21/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DEEPAK SAGGAR</u>			22e. ADDRESS 547 E RIVERSIDE DRIVE SALISBURY, MD. 21801											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 4/25/82			23c NAME OF CEMETERY OR CREMATORIAL FRIENDSHIP U.M. CEM.			23d LOCATION CITY OR TOWN ALLEN			COUNTY	STATE	
24 FUNERAL DIRECTOR NAME JOLLEY MEMORIAL CHAPEL			RT. 2, Jersey Road ADDRESS SALISBURY, MARYLAND			25a DATE REC'D. BY REGISTRAR APR 29 1982			25b. REGISTRAR'S SIGNATURE <u>Janice Jan Marie</u>					

— 1 —

SPRING 1988 REPORT

1.0.1.6 JAVA Zone

14-2232 1107-20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be attached for use. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days of the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days of the death.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified or the death certificate must be certified by a physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	1	1	1	5						
												REG. NO.											
1. DECEASED, NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Hugh JACKSON						VANDER BOGART			APRIL			2 1982			12	30	PM						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS								
MALE			WHITE			MAY 4, 1903			78			YRS.			MONTHS DAYS HOURS MIN.								
7a. BIRTHPLACE (STATE OR FOREIGN)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			11b. KIND OF BUSINESS OR INDUSTRY								
Maryland			U.S.A.						Wicomico			Retired			MD.								
12. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13. STREET ADDRESS			14. FATHER'S NAME FIRST			15. MOTHER'S MOTHER'S MAIDEN NAME MIDDLE								
Salisbury			Peninsula General Hospital			Retired			700 McBride Circle			John Jackson			Margaret								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.					
Maryland			Wicomico			Salisbury									No			220-24-2400					
16c. INFORMANT			17. ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
						Carcinoma of esophagus			2400-														
1509						DUE TO, OR AS A CONSEQUENCE OF (b)																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from 3-28, 1985, to 4-2, 1986, that (II) (we) last saw the deceased alive on 4-2, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE															DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			POWER STREET			SALISBURY MD 21801						4-2-82								
Wilbur B. Ellis Jr.																							
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREAMERY			23d. LOCAL ACTION CITY OR TOWN			COUNTY			STATE								
Burial			4/5/1982			Parsons Cemetery			Salisbury			Md											
24. FUNERAL DIRECTOR																							
Baker & Sons, Salisbury, Md.																							
25. DATE REC'D. BY REGISTRAR OR REGISTRATION SIGNATURE																							
APR 7 1982																							

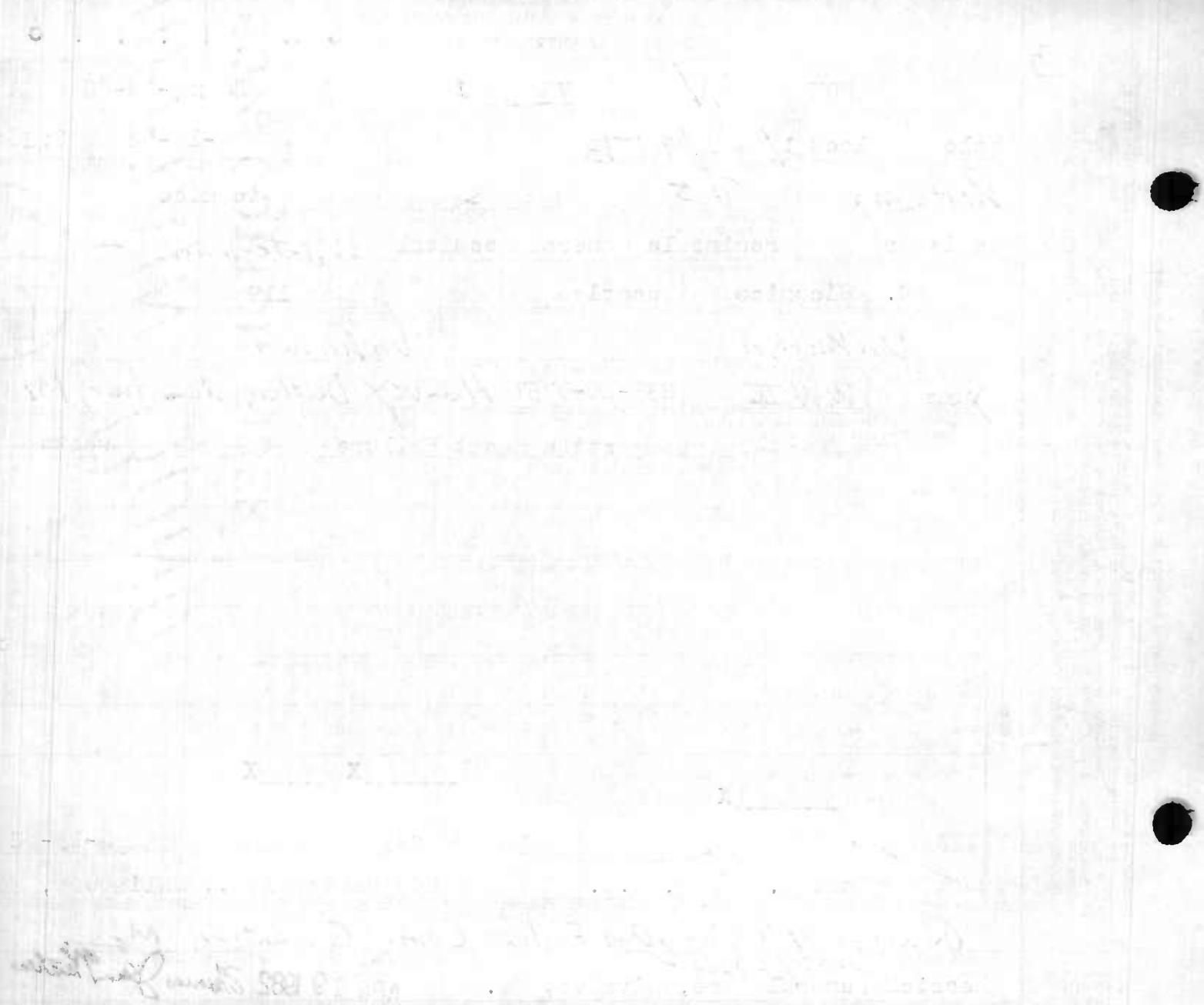
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 11116

1- STATE REGISTRAR		1. DECEASED NAME FIRST ROY MIDDLE W LAST VENABLE						2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH 4 14 82	DAY 19	YEAR 1982	2b. HOUR A M						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH 4 14 82		DAY 19	YEAR 1982	2d. HOUR 7:28A M			
Male		Black		2/22/1909		73													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico					
Kosciusko		U.S.																	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK) Wartzman						12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		Peninsula General Hospital																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 119											
Md.		Wicomico		Quantico															
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST									
Unknown						Unknown													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks							
yes		WWII		235-10-9757		Harvey Dutton, Quantico, Mt.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF 4380 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?											
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>Earl L. Royer</i> TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER																			
DATE SIGNED 4-15-82																			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 409 Camden Ave., Salisbury, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 4/17/82		23c. NAME OF CEMETERY OR CREMATORIAL Odd Fellows Cem.		23d. LOCATION CITY OR TOWN Quantico, Mt.		COUNTY STATE											
24. FUNERAL DIRECTOR NAME		Messick Funeral Home, Bivalve, Md.						25a. DATE REC'D. BY REGISTRAR APR 19 1982		25b. REGISTRAR'S SIGNATURE <i>James J. Messick</i>									
BP																			
DHMH-17 (VR A15 ME (5)) 15M 2/80																			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 111117		
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN MONTH DAY YEAR			2b. HOUR		
			JOAN MARIE WALSH						IF UNDER 1 YR. IF UNDER 24 HRS.			19 M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR	
Female		White		3/22/1904		78 yrs.				April 11, 1982			2d. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD		
Illinois			USA						WICOMICO					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury			Peninsula General Hospital			Co-owner			store					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Florida			Palm Beach			DelRay Beach			YES <input type="checkbox"/>			1820 S. Ocean Blvd.		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
John Frawley			Mary O'Brien											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			341-28-80434			Mari Jo Beckmann			5201 N. 15th St.			minutes		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:			CORONARY OCCLUSION											
IMMEDIATE CAUSE (a) 4100 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			DUE TO, OR AS A CONSEQUENCE OF											
(b)			DUE TO, OR AS A CONSEQUENCE OF											
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Earl L. Royer</i> TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER														
EXAMINER'S NAME (TYPE OR PRINT)			Earl L. Royer, M.D.			ADDRESS			409 Camden Ave., Salisbury, Md.			DATE SIGNED 4/12/82		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial			4/14/82			Queen of Heaven Cemetery			N. Lauderdale, Florida					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
HOLLOWAY FUNERAL HOME, Salisbury, Md.						APR 14 1982			James Jean Martha					
BP		15M 2/80		DHMH-17 (VR A15 ME (5))										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8211118									
												REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
Addie			T.			Walters			April 1, 1982						7 A M						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR		# UNDER 24 HRS									
Female		W		Aug. 14, 1895			86			MONTHS	YEARS	MONTHS	HOURS	MIN							
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.											
Md		USA					Wicomico														
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Salisbury		Peninsula General Hospital										homemaker									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
13b. STATE		13b. COUNTY		13c. CITY OR TOWN			Main Road														
Md		Somerset		Deal Island																	
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
		Henry		Ella			217-48-2386			Harry Walters, Deal Island, Md.			Tyler								
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		18b. IF YES, GIVE WAR OR DATES		18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
no		--																			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												Refractory Congestive Failure									
4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												DUE TO, OR AS A CONSEQUENCE OF (b) <i>302m</i>									
												DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2			P.M.		19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET					CITY OR TOWN		COUNTY		STATE							
22a. I certify that (1) this hospital attended the deceased from 2/14/82 to 4/1/82, that (1) (we) last saw the deceased alive on 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (do) (did) (did not) view the body after death.																					
22b. SIGNATURE <i>J. L. Rafferty</i>												DEGREE		ATTENDING MEDICAL PHYSICIAN <input checked="" type="checkbox"/>		STAFF DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/1/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										<i>PGH</i>									
J. L. Rafferty																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ST. Peter's Cem.			23d. LOCATION City or Town			23e. COUNTY		23f. STATE								
burial		4/4/82						Oriole			Som.		Md.								
24. FUNERAL DIRECTOR NAME		ADDRESS			Pt. 3 Box 354			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
Leroy G. Webster		Pr. Anne, Md.						APR 6 1982			<i>John J. Miller</i>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
8 2 1 1 1 9											REG. NO.
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
EPPIE Cornelia WESSELLS				APRIL 18 1982				7 P M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
F	W	11-23-93			88			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		U.S.A						WICOMICO			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
SALISBURY		SALISBURY NURSING HOME			Housewife			None			
13a. STATE Va.		13c. CITY OR TOWN Accomack Co. Virginia			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Cornelius			Bonawell	Mollie. Drummond							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		223-24-6908			Agnes Nelson			St Petersburg, Fla			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCVD</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes Mellitus</u> yes											
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Arteria Stenosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Joseph C. Fitzgerald M.D.</u>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>4-19-82</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
DR. JOSEPH C. FITZGERALD, M.D.		Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>Burial</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Dorning Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Dale Hall</u>			COUNTY STATE	
24. FUNERAL DIRECTOR NAME <u>Null</u>		ADDRESS <u>Temperanceville, Va 23472</u>		25a. DATE REC'D. BY REGISTRAR <u>APR 26 1982</u>			25b. REGISTRAR'S SIGNATURE <u>Anne Jane North</u>				

